Third Party Liability Department

INDIANA HEALTH COVERAGE PROGRAMS

Third Party Liability Operating Procedures – Volume II

LIBRARY REFERENCE NUMBER: CLTP10001 – VOLUME II
REVISION DATE: SEPTEMBER 2004
VERSION 3.0

Library Reference Number: CLTP10001

Document Management System Reference: TPL Operating Procedures – Volume II

Address any comments concerning the contents of this manual to:

EDS Document Management Unit
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
Fax: (317) 488-5169

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 3.0	June 2004	All	Rewrite.	TPL Department
Version 3.0	September 2004	All	Prepare for review.	Leo Dabbs

Table of Contents

Section 1: Health Unit

Overview

Having private insurance does not exclude an individual from receiving Indiana Health Coverage Programs (IHCP) benefits. Many IHCP members have other insurance in addition to the IHCP. Other resources include but are not limited to the following:

- Commercial health insurance policies, both group and individual
- Medicare
- TRICARE, formerly know as CHAMPUS
- Indiana Comprehensive Health Insurance (ICHIA)
- Indemnity policies that pay a fixed per diem for hospital or nursing home services
- Auto insurance
- Homeowner's insurance
- Worker's compensation
- Other liability insurance

Federal regulation *(42CFR 433.139)* establishes that the IHCP is always the payor of last resort. The Health Unit maintains a table of third party resource data for claim editing, as well as handling TPL-related claim attachments. This ensures that the IHCP is the payor of last resort.

Toll-free and local telephone lines are available to insurers, county caseworkers, providers, attorneys, or other individuals with specific TPL questions.

Telephone Inquiries

The Health Unit telephone lines are available from 8 a.m. to 12 noon and from 1 p.m. until 5 p.m. Eastern Standard Time (EST) Monday through Friday, excluding State holidays. The health analyst receives calls from various entities such as caseworkers, IHCP members, insurance carriers, and providers. Automatic call distribution sends incoming calls to the first available health analyst. If all phone lines are busy, the caller can leave a message.

Health analysts screen calls to determine if it is a TPL-related issue. If not, the health analyst redirects the caller to the correct entity. For example, the health analyst directs a provider calling to request information about a claim denial or processing to contact EDS Customer Assistance. The health analyst directs a member calling with a question about eligibility to contact their caseworker.

Casualty Calls for Health Analyst

Health Analyst Name _____ Date_____

Member Name _____RID_____

How were you injured? Fall Automobile At Work Product

Who

What

When

Where

Is someone going to pay for your injuries?

Homeowners Insurance
Renters Insurance
Auto Insurance
Worker compensation
Manufacturer

Have you been contacted?

Insurance Company
Attorney
Doctor/Nurse/Dentist/Hospital

Contact Information

Insurance Company	Address	Phone #
Insured Member	Address	Phone #
Attorney Name	Address	Phone #
Member Name/Guardian	Address	Phone #

Figure 1.1 – Casualty Calls for Health Analyst Form

Casualty Inquiries

Accident/Trauma letters are system-generated, based on accident or trauma diagnosis codes submitted on claims and sent to the member along with an accident/trauma questionnaire. The health analysts often receive casualty calls. The health analyst completes a *Casualty Call for Health Analyst* form. Figure 1.1 provides an example of this form. If the member is calling concerning receipt of the *TPL Accident/Trauma Questionnaire* the Health analyst can close out the TPL casualty case based on the information provided. If the member reports no accident, or an accident that does not involve a liable third party, or no other insurance, the Health analyst can close the case and update Indiana*AIM*. Detailed procedures for responding to accident/trauma leads are in Volume III of the TPL operations manual.

Use the following steps to close the case.

1. From the main production menu, click **Third Party Liability**. The *TPL Menu* displays.
2. Click **Case Tracking**. The *Case Tracking Menu* displays.
3. Click **Casualty Case**. The *Casualty Case Search* window displays.
4. Type the member's ID number in the *RID Number* field and click **Search**.
5. Double-click the highlighted information.
6. Type the current date in the *Date* field.
7. Click **No Further Pursuit** from the drop-down box.
8. Click **Save**. A message prompts the user to add a note.
9. Click **Yes**, to add a note. The *Comment/Note* window displays.
10. Type comments related to the phone call. Click **Save**.
11. Click **Exit** to return to the main menu.

Caseworker Inquiries

Caseworkers use the toll-free or local telephone lines to confirm or request carrier numbers, to terminate or add coverage, or to confirm what Indiana*AIM* shows as the IHCP member's TPL coverage. Figure 1.2 charts the steps to follow for caseworker inquiries.

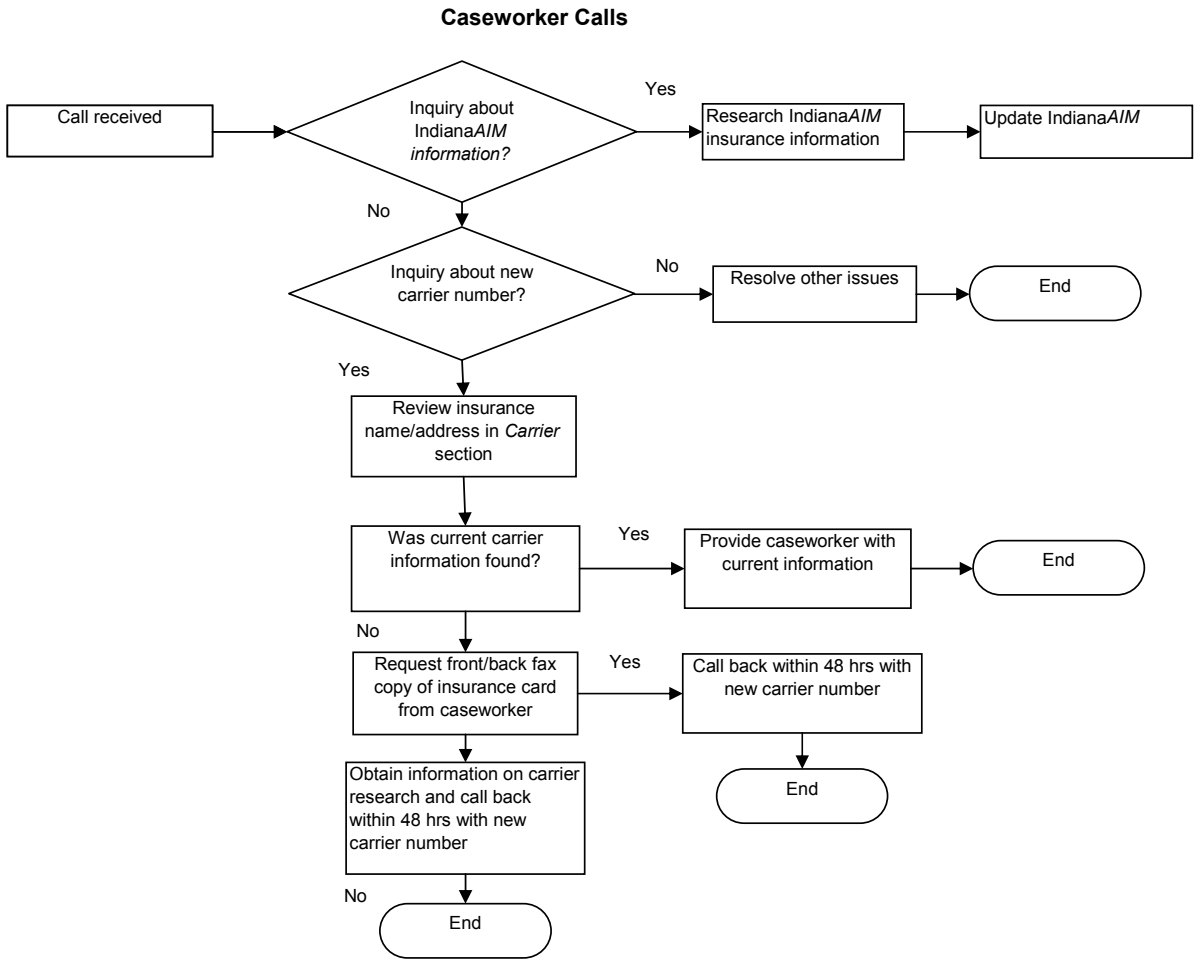

Figure 1.2 – Caseworker Calls Flowchart

Member Inquiries

The health analyst uses Indiana*AIM* to respond to requests to terminate a member's TPL coverage, indicate additional coverage, or modify current coverage. Supporting documentation is required when a member requests a change to TPL coverage information. The member must provide supporting documentation by letter or facsimile from the insurance carrier. Health analysts complete change requests from a caseworker immediately. Figure 1.3 charts the steps for completing member calls.

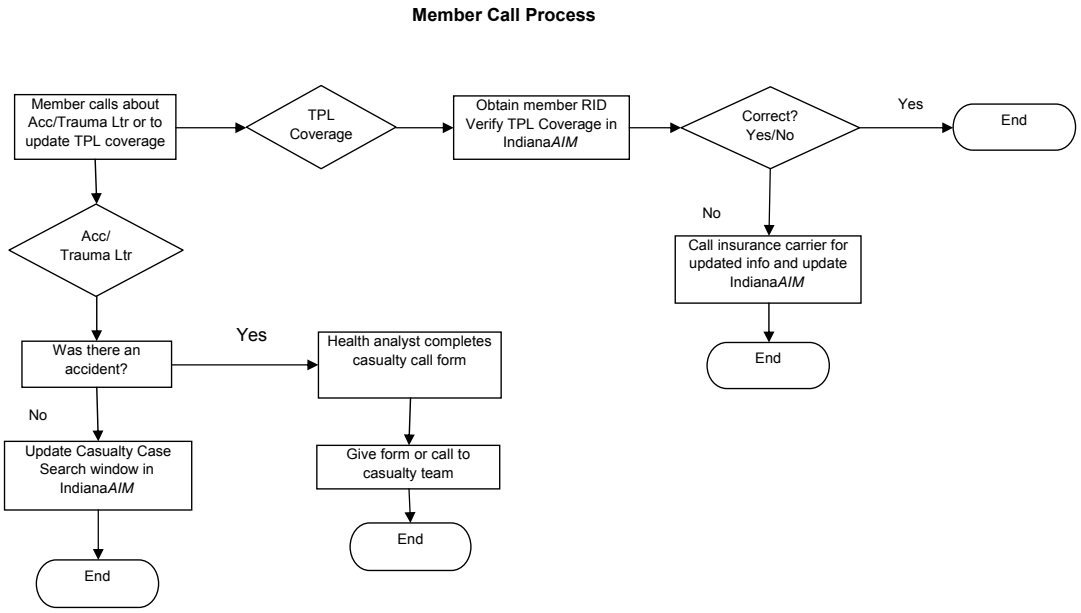

Figure 1.3 – Member Call Flowchart

Members can call to request a *Certificate of Credible Coverage* document. This certificate validates the period the member was covered by the IHCP and the effective dates. The analyst directs the member to contact their caseworker for additional coverage information.

When a members calls to report changes or new medical coverage information, the analyst must ask for the insurance carrier name, policyholder name and number, the type of coverage, and who the medical plan covers. The analyst must call the carrier to verify the information provided by the member. If the analyst cannot reach the carrier by phone, the analyst must send a *TPL Questionnaire* to the insurance carrier. On receipt of the completed questionnaire, the analyst can update Indiana*AIM.* This section provides procedures for updating the Indiana*AIM*.

Carrier Call Process

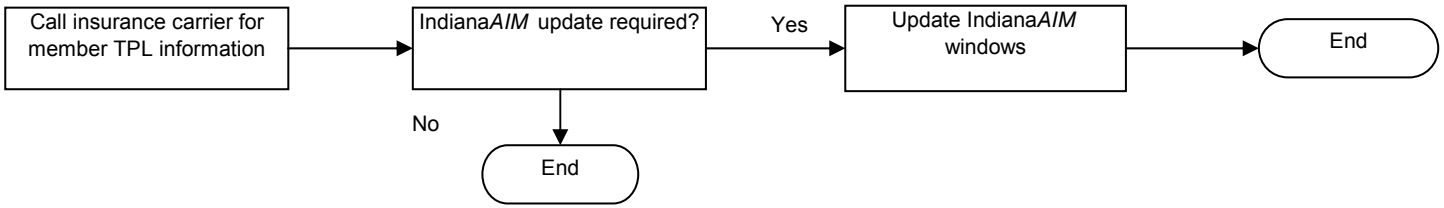

Figure 1.4 – Insurance Carrier Calls Flowchart

Provider Inquiries

Providers call to verify a member's TPL coverage. The health analyst uses Indiana*AIM* to answer the request. If a provider is requesting an update to the IHCP member's coverage, supporting documentation is required either by mail or facsimile. This section provides the steps for updating the system. Figure 1.4 charts this procedure.

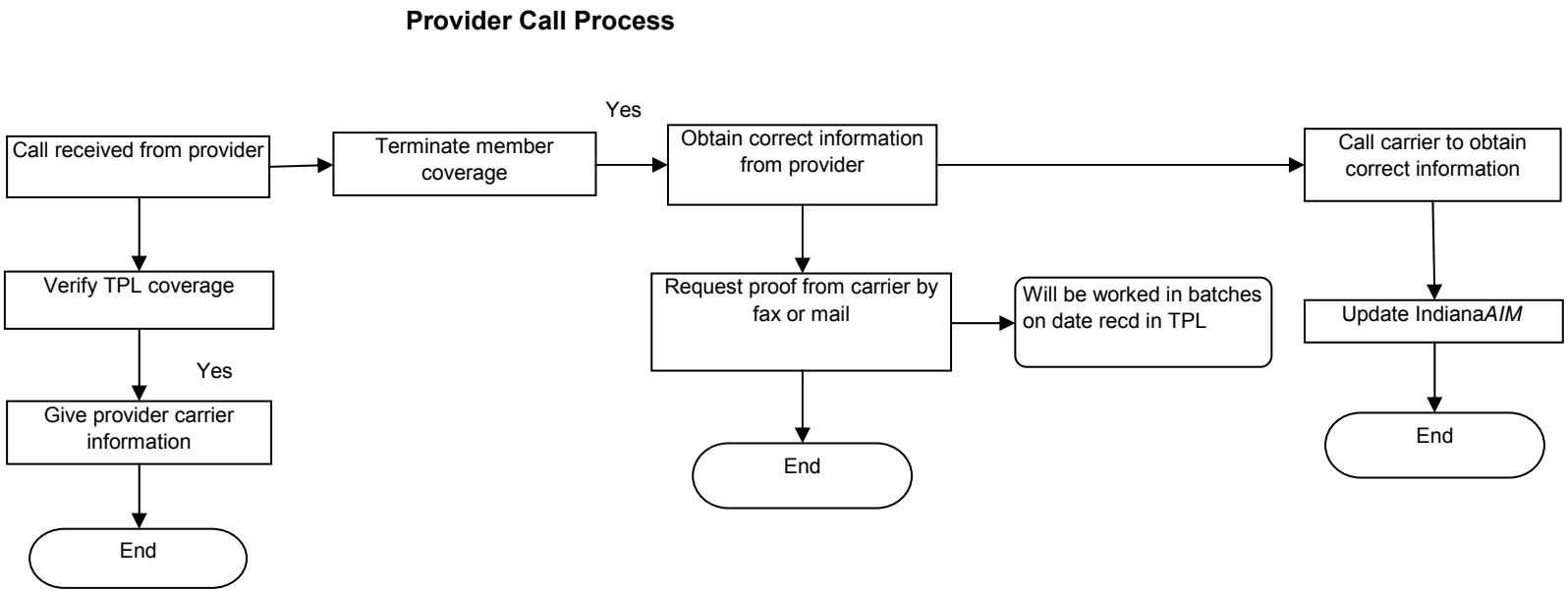

Figure 1.5 – Provider Calls Flowchart

Daily Procedures

At the start of each day, the health analyst logs into Indiana*AIM,* opens the *TPL Resource* windows, and logs into the phone system.

Indiana*AIM* provides the ability to update the TPL information base, as well as retrieve TPL information.

Phone System Automatic Call Distribution

To log into the phone system each morning, press the **Login** button and using the phone keypad, type in the user ID. This automatically puts the user in *AUX* or *busy* status. After logging into the system, press the **AVAIL** button. This automatically directs calls to the analyst.

Press the **AUX** button and then **Auxiliary Work**, and type in a reason code to place the phone in auxiliary or *busy* status. Figure 1.6 provides the reason codes.

Reason Code	Aux Reason Code Description	Logout Reason Code Description
1	Lunch	Lunch
2	Break	Break
3	Other	End of shift
4	Meeting	Meeting
5	Training	Training
6	Reports	Outside appointment
7	Special project	Special project
8	Claims res/pull	Other meeting
9	PVS research	Vacation
Default code	System default	System default

Figure 1.6 – Auxiliary Reason Codes

The After Call Work (*ACW)* button places the phone in busy status. This function is different than AUX and is not used in TPL.

When the call warning threshold is reached or exceeded the *Q-Calls* associated status lamp flashes. Press **Q-Calls** to view the following:

- Number of calls in queue
- Length of time the oldest call has been waiting

Use the *Logout* button to log out of the phone system before leaving for the day. Press **Logout** and type reason code **3** to turn off all lights on the telephone display.

Press the **Vu Stats** button to view statistical information in the display.

Logon to IndianaAIM

1. Click the **Indiana*AIM* Production** icon on the desktop. The *System Logon* window displays.

Figure 1.7 – IndianaAIM Logon Window

2. Type the user ID and press **Tab**.
3. Type the password and press **Enter**, or click the **OK** button. The *Main Menu – Production* window displays.

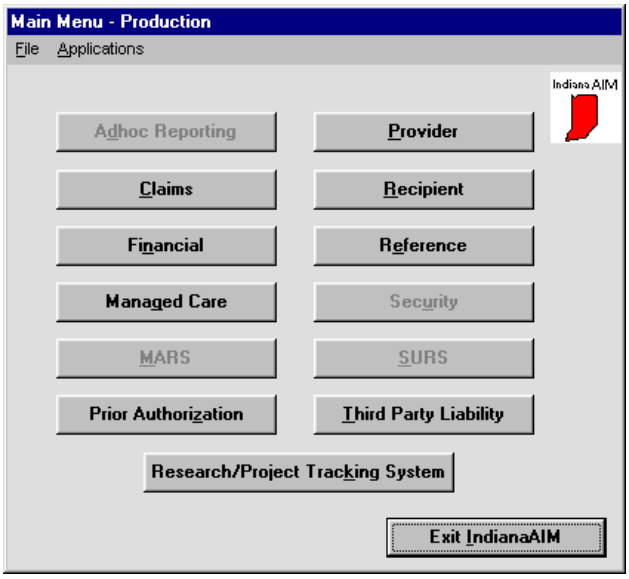

Figure 1.8 – Indiana*AIM* Main Menu Window

4. On the *Main Menu – Production* window, click **Third Party Liability** to view the *TPL Menu* and access specific TPL-related information.

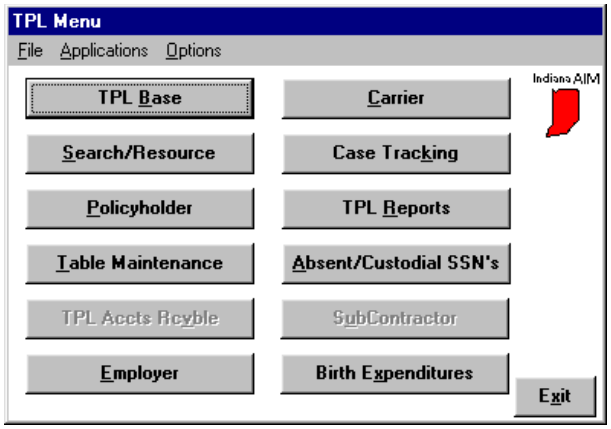

Figure 1.9 – TPL Menu Window

TPL Resource File

Indiana*AIM* maintains TPL Resource data by systematic updates from EDS or from the county caseworkers, electronic updates from Health Management Systems (HMS) and Public Consulting Group (PCG). The county caseworkers do not use Indiana*AIM* to update the IHCP member's file. The county caseworkers use ICES. The caseworker enters TPL information in the ICES system and at the end of the day, EDS receives the information electronically. EDS runs a job to update Indiana*AIM* each evening. Each month HMS and PCG also sends a file of resource file updates.

The *TPL Detail Resource* window stores the TPL information. The health analyst uses the same window to update, add, or delete TPL information. The health analyst verifies all policy information with the carrier before adding, deleting, or terminating TPL information on this screen. The health analyst updates information taken from the provider or member only after receiving a letter or facsimile as verification. The health analyst makes caseworker update requests immediately. The system does not display the updated information for 48 hours.

1. Click **Search/Resource** to open the *TPL Resource* window

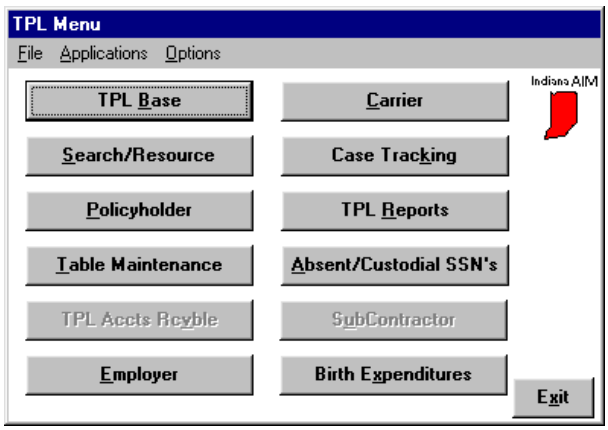

Figure 1.10 – TPL Menu Window

2. Type the member's RID number in the *RID No.* field and click **Search**. The member information displays.

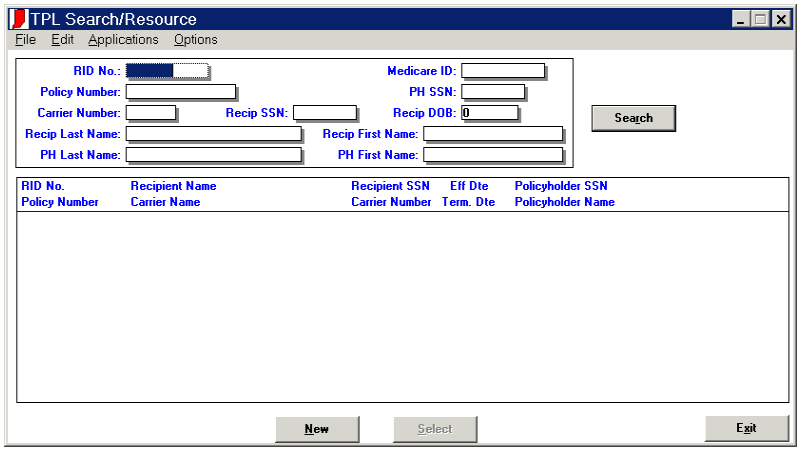

Figure 1.11 – TPL Search/Resource Window

3. If the member's RID number is not available, search by the member's Social Security number (SSN). Type the member's SSN in the *PH SSN* field and click **Search**. If there is a match, proceed to step 7. If no match is found, proceed to the next step.

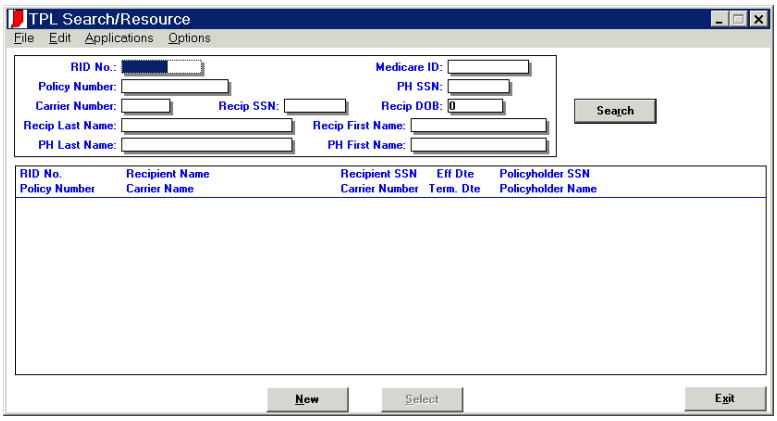

Figure 1.12 – TPL Search/Resource Window

4. If the member's RID number is not available, search by the member's first and last name. Type the member's last name in the *Recip Last Name* field and type the member's first name in the *Recip First Name* field and click **Search**. If there is a match, the member's name populates the fields or a list of names displays if there are multiple matches.

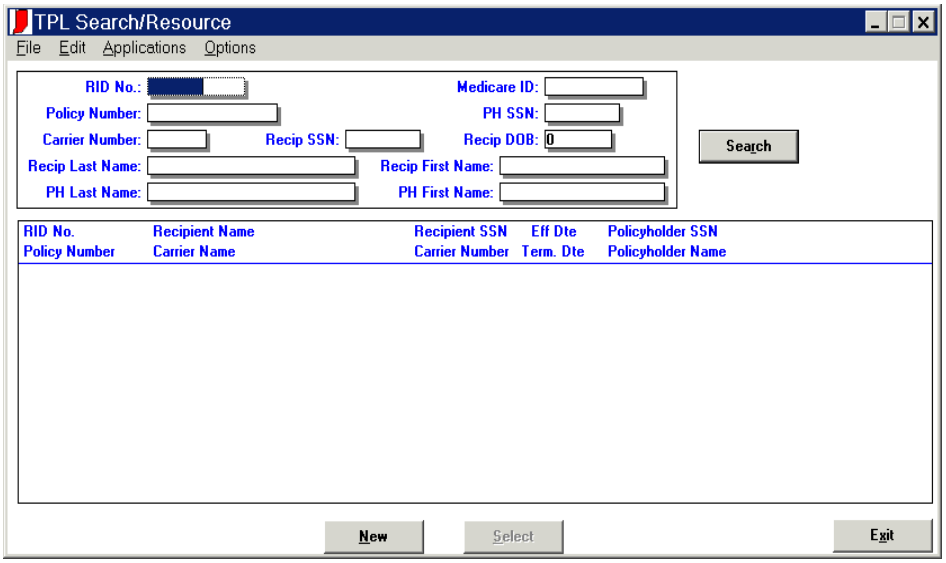

Figure 1.13 – TPL Search/Resource Window

5. If multiple names appear, highlight the correct name and click Select.
6. After locating the correct member, a screen displays containing the requested information. Locate the active coverage indicated with an end date of *2299/12/31*, highlight the line, and click **Select**.

7. The *TPL Detail Resource* screen displays. This screen displays the carrier number, carrier name, policyholder name, policyholder ID, Policyholder SSN, policy number, group number, effective date, and termination date.

Delete TPL Detail Resource

When a duplicate is discovered or when a policy number is entered by mistake, the policy must be deleted from the system.

1. To delete a policy, at the *TPL Detail Resource* window click **Options** and **Coverage Type**. The TPL Resource Coverage List displays.
2. Click the coverage code listed or highlighted.
3. Click Select. The TPL Resource Coverage Type/Premium Add window displays.
4. Click **Delete**.
5. Continue this process until all coverage codes are deleted and the TPL Detail Resource window displays.
6. Click **Delete**. The *Warning* box displays. To delete, click **Yes**; to cancel, click **No**.

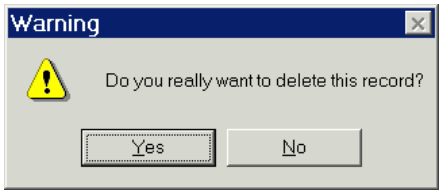

Figure 1.14 – Warning Box

The warning box displays for the second time. Click **Yes**. A *policy deleted* message displays.

Table 1.1 provides definitions for TPL coverage codes.

Table 1.1 – Coverage Code Definitions

TPL Coverage Code Definition		
Code	**Title**	**Definition**
A	Hospitalization or Hospital/Surgical	Provides specific benefits for hospital services including daily room and board and surgery services during a hospital confinement.
B	Medical	Provides benefits for all types of medical and hospital expense up to a maximum benefit. Such contracts are usually subject to deductible and coinsurance, and may include co-payments.
C	Major Medical	Provides benefits for various expenses incurred for medical care. May include diagnosis for preventative

Table 1.1 – Coverage Code Definitions

TPL Coverage Code Definition		
Code	**Title**	**Definition**
		as well as treatment. Does not include hospital charges.
Q	Major Medical or Hospitalization	Provides benefits for various types of medical and preventative care including inpatient and outpatient care. This code must be used and not A, B, C or A, C or A, B
D	Dental	Provides benefits for dental services.
E	Pharmacy	Provides benefits for prescription drugs.
F	Cancer	Provides benefits only for cancer related charges.
G	Skilled Care	Provides benefits only for nursing care in a facility.
H	Home Health	Provides benefits for home health services.
I	Optical/Vision	Provides benefits for optical and vision services.
K	Mental Health	Provides benefits for behavioral health services for inpatient and outpatient care
L	Indemnity	Provides benefits for a specific medical condition, which is paid out in one lump sum or a dollar amount per day.
P	Medicare Supplemental Medicare Part A	Provides benefits in addition to Medicare coverage. This does not replace Medicare coverage but enhances it. (Note: If the plan replaces Medicare coverage, do not load as TPL coverage) If the supplemental or replacement policy includes coverage for Pharmacy (E) or Nursing Facility (G) code separately.
O	Medicare Supplemental Medicare Part B	Provides benefits in addition to Medicare coverage. This does not replace Medicare coverage but enhances it. (Note: If the plan replaces Medicare coverage, do not load as TPL coverage) If the supplemental or replacement policy includes coverage for Pharmacy (E) or Nursing Facility (G) code separately.

Locate, Add, or Delete Coverage Codes

Providers often request information about the type of insurance coverage a member has with the carrier and the carrier's name and address. Use the following steps to locate, add, and delete coverage codes.

1. At the *TPL Detail Resource* window, click **Options**, and click **Coverage Types**. This screen identifies the type of coverage the member currently has with that carrier.
2. To delete a coverage code, highlight the code, and click **Select**.

3. To add a coverage code, click **New,** type the appropriate and click **Save**. Exit all windows until the TPL Search/Resource window displays.
4. Click **Search** to view the policy for accuracy.
5. At the **TPL Search Resource** window, click **Options.**
6. Click **Comments**. The *Recipient Comments* window displays. Type the current date, health analysts' initials and the nature of the update. Include the name of the insurance carrier.
7. Click **Save** and **Exit**.

Locate Carrier Number

The carrier number is located using Indiana*AIM*. Use the following steps to obtain a carrier number from Indiana*AIM*.

1. Request the carrier name, address, and phone number from the caseworker, IHCP member, provider, or locate the information on written documentation such as the *TPL Questionnaire*.
2. At the *TPL Menu*, click **Carrier** to view carrier information.

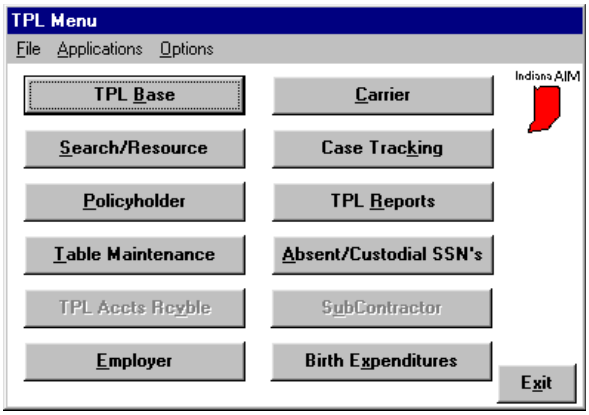

Figure 1.15 – Indiana*AIM* TPL Menu Window

3. At the *TPL Menu*, click **Carrier**. Type the carrier name and click **Search**. The window may display one or more carrier names.

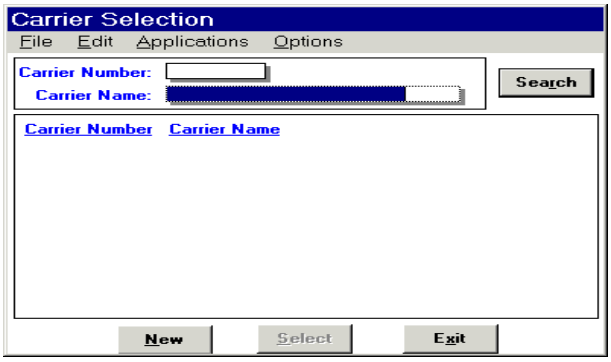

Figure 1.16 – Carrier Selection

4. Click the appropriate carrier name and click Select.

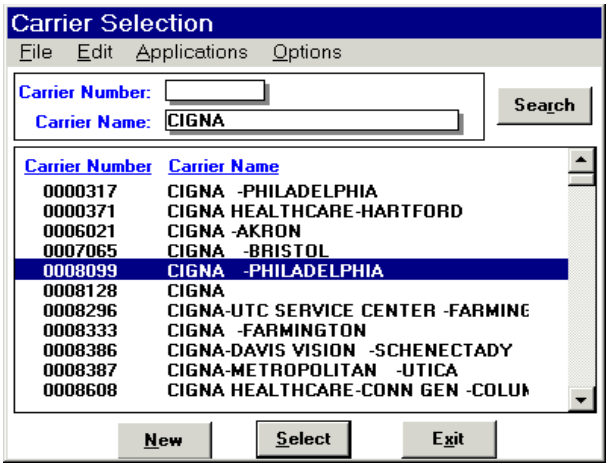

Figure 1.17 – Carrier Selection

5. The *TPL Carrier* window displays.

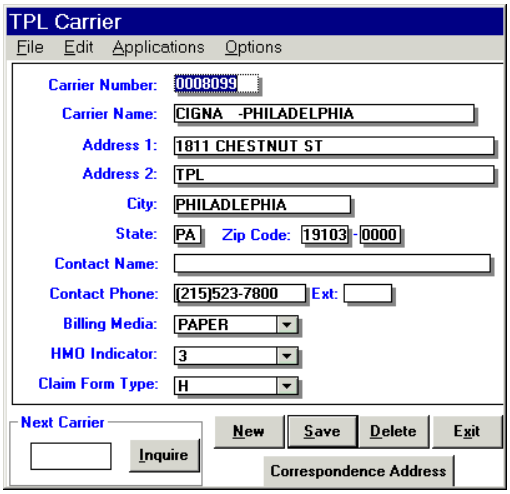

Figure 1.18 – TPL Carrier Window

6. Verify the carrier information on the screen. If this information matches, provide the carrier number to the requester or write it on the correspondence being reviewed. Should the information not match and numerous carrier selections are provided, start the process over to locate the correct carrier number.
7. Click **Exit** to return to the *Carrier Selection* window.

The TPL carrier file is updated periodically to provide the most often used codes. A list of the most often used codes is located at L:/Package Three/Health/Common Carrier Codes/Most Often Used Carrier Codes.doc. If the carrier code cannot be located, look on this list first. If the carrier code is not on the list, obtain the following information:

- Carrier name
- Carrier address
- Carrier phone number
- Copy of front and back of ID card

The health analyst verifies that the carrier is not in the system and calls the carrier to verify the policy and mailing address. The red *Carrier Numbers* folder is located in the Health Unit, contains the *Current Quarter Carrier Listing Additions* log. At the next available number, list the carrier name, address, and phone number.

Also provide the case worker name and phone number if applicable. An example of this log is provided in Figure 1.19.

Number	Insurance Carrier Name/Address/Phone	Caseworker Name/Phone
17656	ABC Co., 234 Main, Anywhere, USA 12345, 121-234-5678	Jan/121-456-6543
17657	Insurance, Inc. 987 E. 1st St. Anytown, USA 43215, 345-678-9876	Susan/898-765-3647
17658		

Figure 1.19 – Example of Insurance Carrier Number Log

Indiana*AIM* is updated periodically using this log.

1. To update Indiana*AIM*, at the *TPL Menu* window, click **Carrier**. The *Carrier Selection* window displays.
2. Click **New**. A blank *TPL Carrier* window displays.
3. Using the *Insurance Carrier Number* log, type in the carrier number, name, address, and phone number.
4. Click **Save**.
5. Click **Exit**.

Daily Telephone Reports

The following procedure tracks toll-free and local phone line data daily, to monitor the phone contract requirements. The compiled information is for internal use and as requested by the State.

The systems administrator delivers the CMS telephone reports daily to the TPL analyst. The procedures in this section use information from CMS, CentreVu®, and OnDemand telephone reports. The following reports provide daily statistics:

- CentreVu® Report
- WorldCom Report
- Phone Tracking Spreadsheets

CentreVu® Report Procedure

To pull the daily report from CentreVu® which reports the percent answered <120 seconds, hold time, and average speed answered complete the following steps below.

1. Login to CentreVu®.
2. Click **Commands**.
3. Click **Reports**.
4. Click **Historical** tab.
5. Click **Designer** in the *Category* window.
6. Click **PRC 35/REC28 Summary Report** in the *Report* window.
7. Click **OK**. Set *Split/Skills* on **TPL Backup; TPL 3rd Party** only.

8. Click **Browse** and click the appropriate date.
9. Click **Clear**, then click the date. Always use the previous business working day.
10. Click **OK** and **OK**. The report for the date selected displays.
11. Click **Report**.
12. Click **Print**.
13. Click **OK**.
14. Exit CentreVu®.

Updating Phone Tracking Spreadsheets

The TPL phone spreadsheets track data daily from OnDemand reports, login/logout reports, and the local phone call volume. To update the phone tracking spreadsheets the following procedure direct the user to first update the TPL spreadsheet, then update the Buy-In spreadsheet using the following steps:

1. Open Microsoft Excel.
2. Click **File**.
3. Click **Open**. Open the file from the following directory: *L:\Package Three\TPL\Phone Reports\TPC40CCYY.xls,* if updating the report for the TPL 800 line. Open *MBC24CCYY.xls,* if updating report for the Buy-In line.
4. To update the TPL spreadsheet, continue with Step 5, to update Buy-In spreadsheet, skip to Step 9.
5. From the *PROVDPHN30* TPL report, type the total calls in the *Total Calls Attempted* column in the appropriate date row.
6. From the *PROVDPHN30* TPL report, type the total answered in the *Total Calls Answered* column in the appropriate date row.
7. From the CMS *Interval VDN Report*, for local TPL line, type the calls in the *Local Calls* column in the appropriate date row.
8. Review the *Split TPL 3rd Party* and *TPL 3rd Party backup Login/Logout* reports. Verify staffing from 7:30 a.m. to 5 p.m. Type **Y** for yes, or **N** for no on the spreadsheet in the **Login/Logout** column. If *no*, for the above time frame, notify the TPL supervisor immediately.
9. Click **Save**.
10. To update the Buy-In spreadsheet open the file name listed for Buy-In from step **3**.
11. From the *PRVDPHN20* Buy-In report, type the total calls in the *Total Calls Attempted* column in the appropriate date row.
12. From the *PRVDPHN20* Buy-In report, type the total answered in the *Total Calls Answered* column in the appropriate date row.
13. Review the *Split Buy-In Login/Logout* report. Verify the line was staffed from 8:00 a.m. to 5 p.m. To report in the spreadsheet type **Y** for yes, or **N** for no in the *Login/Logout* column. TPL is not currently reporting the Buy-In phone line activity in the *Monthly Status* report.
14. Click **Save**.
15. Exit Microsoft Excel.
16. Staple all buy-in and *TPL CMS* reports and the ONDEMAND printouts together, and file in the appropriate month's folder and file cabinet.

Monthly Telephone Reports

The following procedure pulls the month-end requirement data from Lucent CentreVu® by pulling the *Designer* report. Statistics provided are as follows:

- A TPL analyst answered incoming calls within two minutes, 95 percent of the time; and hold time must not exceed two minutes.
- The average hold time must not exceed 30 seconds.
- The call length is sufficient to ensure adequate information given to the caller.

The *Designer* report auto calculates the information from the Lucent CMS *Split/Skill Call Profile* reports. To generate the complete the following steps:

1. Log in to Lucent CentreVu®.
2. Click **Commands**.
3. Click **Reports**.
4. Click **Historical**.
5. In the *Category* field click **Designer**.
6. Click **PRC35/REC 28 Summary Report**.
7. Click **OK**.
8. Next to the *Date* field click **Browse**.
9. Click **Clear**.
10. Click **Range**.
11. Click the first day and the last day of the calendar month to highlight the appropriate month for reporting.
12. Click **OK**.
13. Next to the *Splits/Skills* field click **Browse.**
14. In the *Available Splits Option* box click **TPL 3rd Party**.
15. Click **Add**.
16. Under the *Available Splits Option* box click **TPL Backup**.
17. Click **Add**.
18. On the *Browse Splits/Skills* window click **OK**.
19. Click **OK** on the *PRC35/REC28 Summary Report* window. The *Splits/Skills TPL 3rd Party, TPL Backup Report* displays.
20. Click **Report**.
21. Click **Print**.
22. Click **OK**.
23. Exit *Lucent CentreVu®.*

After obtaining the requirement data from *Lucent CentreVu*®, the analyst must obtain a copy of the phone tracking spreadsheet that contains data for the following:

- Percent answered
- Total number of local calls
- Login/logout verification

To print a copy of the phone tracking spreadsheet complete the following steps:

1. Open Microsoft Excel.
2. Click **File**.
3. Open the file using directory path *L:\Package Three\TPL\Phone Reports\TPLq#yyyy* and click **Open**. The file name is in quarter number and year format (QCCYY).
4. Click the appropriate month worksheet tab.
5. Review the spreadsheet to ensure all the daily information is included.
6. Highlight all the data in the spreadsheet.
7. Click **File**.
8. Click **Print**.
9. Click **Selection**.
10. Click **OK**.
11. Exit Microsoft Excel.

Complete the following steps to calculate the total calls received for the month by the TPL Unit for the monthly report:

1. Obtain a copy of the *Monthly Split/Skill Call Profile* report for **Split/Skill: TPL 3rd Party** (column? 72) and **Split/Skill: TPL Backup** (column? 75).
2. Add the **Total Calls Answered** + **Total Calls Abandoned** from both the *Monthly Split/Skill Call Profile* reports for **Split/Skill: TPL 3rd Party** and **Split/Skill: TPL Backup**. This figure represents the total calls received by the TPL Unit for the month.

Tracking Health Batches

Health batches consist of mail received from providers, caseworkers, and insurance carriers. When the provider returns the questionnaire by mail, the TPL Unit sorts, batches, and tracks the number of items in health batches. Figure 1.19 and 1.20 provides a sample batch statistics and batch cover sheet. The TPL Health Batches report inventory by piece. A *piece* is defined as a per member transaction whether it is terminating a policy, updating existing resource information, or adding new resource information.

TPL HEALTH BATCH STATISTICS

2004

DATE	PIECES REMAINING	OLDEST DATE	CURRENT DATE
07/28/04	**2,464**	**07/02/04**	**NOW AT 18 Days**
.	**Batch Numbers**	**190-01**	**FOR 15 DAY GOAL**

TOTAL BATCH COUNT **13**

TPL CURRENT BATCH WORKING ON: **184-04E**

Figure 1.19 – Health Batch Statistics

TPL HEALTH BATCH

COVERSHEET

CLAIM SUPPORT USE

JULIAN DATE _____

BATCH TYPE: ☐ **HEALTH** ☐ **TERMCL**

NUMBER OF PIECES _____

CLAIM SUPPORT INITIALS _____

TPL USE

CHECK OUT DATE _____

ANALYST INITIALS _____

COMPLETION DATE _____

ACTUAL PIECE COUNT _____

COMMENTS _____

Claims Support: Please use green paper for the batch coversheets. This helps to easily identify the health batches.

Figure 1.20– Health Batch Cover Sheet

Daily Tracking Procedures

1. Obtain the new batches for the current date. New batches are obtained in the following ways:
   - E-mail – Refer to the *Daily TPL E-mail Request Procedures*
   - Daily mail – check TPL inbox in file cabinet
   - Fax – Located by the fax machine
2. Group all e-mails in a batch of 50 or less and indicate the Julian date on the front of the batch cover sheet. The Julian date is the number of days since January 1, of any specific year. Figure 1.19 provides an example of the batch cover sheet.
3. Group all daily mail in a batch of 50 or less and indicate the Julian date on the front of the batch cover sheet. The health analyst verifies the number of pieces on batch sheets completed by mail room staff.
4. Group all faxes in a batch of 50 or less and indicate the Julian date on the front of the batch cover sheet.
5. Steps 2, 3, and 4 create three groups of batches representing e-mail, mail, and faxes. The Julian date should represent the number of batches on that date, for example 194.01, 194.02, and 194.03.

Answer Health Analyst E-mail Messages

1. Open Microsoft Outlook and double-click **Public Folders**.
2. Double-click **All Public Folders**.
3. Double-click **Group Mailboxes**.
4. Double-click **INXIX TPL Requests**. A list of requests displays. Highlight the last one on the list.
5. Click the **Printer icon** to print a hardcopy. Although it doesn't always happen, the envelope will usually change to appear as an open envelope.
6. After the copy prints, click **X** on the toolbar to delete the e-mail.
7. Repeat steps 7 and 8 for each e-mail. Use the Julian date, the batch number and an **E**. For example, e-mails received on June 28, 2004 are indicated as 180-03E. Be sure to indicate the number of pieces and analyst's initials. The batch sheet template is stored at directory path *L: Package Three/TPL/Health Batches 2004/Health Batches 2004TPL Health Statistics*. Extra batch sheets are available in the unit. Make additional copies as necessary so a supply is always available for use by the health analysts.

Update Health Batch Spreadsheet

1. After all batches are prepared, open the Health Batches spreadsheet at directory path L: Package Three/TPL Reports/Health Batch Report/Health Batches 2004.
2. Click the first tab labeled TPL Health Statistics and complete the information.
3. Click the current month's tab at the bottom of the spreadsheet and type in the information for all the new batches for the current day.
4. Click **Save**.
5. Gather the completed batches for the current date and type the date completed into the *Health Batch 2004* spreadsheet and the analyst's initial.

6. File the completed batches in the appropriate file cabinet.
7. Post the TPL Health Statistics sheet in the designated TPL area.

Daily Returned Mail Procedures

1. Check the basket inside the filing cabinet in the Health Unit for any returned mail.
2. If there is a yellow *return to sender* label on the front of the mail, use correction tape to cover the address on the document and write the corrected address.
3. If there is no address on the yellow return label, or there is no return label, use the carrier file or other resources for the phone number to obtain an alternate address for the carrier.
4. After completing Steps 2 and 3, if necessary use the *Recipient Search* window and the RID number to correct the carrier information.
5. If the carrier file is incorrect, and the health analyst cannot locate new information, type *Do Not Use Address* in the carrier file.
6. After all corrections are made, place the corrected document in a new envelope and place in the outgoing mail basket outside conference room 903.

Preparing Batches for Warehouse Storage

Completed health batches are prepared monthly for storage at the warehouse.

1. Verify all completed batches are in order by Julian date and batch number, such as 124-03E, 124-04TC, and so forth.
2. Place the completed batches in numerical order in a storage box. Note the first and last batch number placed in the box.
3. Obtain the *Warehouse Log* binder, go to the *Health Warehouse Log* section, note the next box number and write that number on the first storage box. Note on the box label and in the log, the date sent to storage, indicate *HB* in description field, the date range of the contents, and the destroy date. The destroy date is always three years for batches. Information on the box and in the log is as follows:

   Box 90, sent to storage 061004, description HB, date range of contents 043004-051304, destroy date 2007.
4. Place the appropriate label on each box until all boxes are labeled and logged.
5. Place the labeled boxes in the appropriate place for pick-up and delivery to the warehouse.

Determining Monthly Batches Received

1. Open Microsoft Excel.
2. Click **File**.
3. Click **Open**. Open the file from directory path *L:\Pkg Three\Tpl\Health\HealthBatches\HealthBatches2004.xls.*
4. Click **D3**.
5. Click **Data**.
6. Click **Filter**.

7. Click **AutoFilter**.
8. From the drop-down list click **Batch Date**. The report includes data reported by calendar claims cycle dates. To determine where to start the current month's cycle, refer to the claims cycle calendar for the end date of the prior month cycle.
9. Click **Custom**.
10. In the first drop-down list click **is greater than or equal to**.
11. In the second drop-down list, to the right, type the Sunday date following the last cycle week reported.
12. In the third drop-down list, to the right, click **is less than or equal to**.
13. In the fourth drop-down list, to the right, type the following Saturday date. This represents the number of batches received for the week.
14. Click **OK**. Rows that meet the criteria display. If no rows display, go to Step 14.
15. Click the blank cell after the last row of the data in the *# of pieces* column and drag the mouse to the header row, highlighting the cells above to add.
16. Click **Auto Sum** on the toolbar.
17. Highlight all of the numeric data in Column D.
18. Click **Enter**.
19. Highlight all of the current information on the spreadsheet.
20. Click **File**.
21. Click **Print**.
22. Click **Selection**.
23. Click **OK**. Retrieve the printout from the printer and write the cycle dates for that week on top of the page.
24. Delete the sum calculation at the end of the *# of pieces* column.
25. Click the **Batch Date** drop-down list and click **ALL**. This turns off the data filters on the spreadsheet and returns the data back to the column. Repeat steps 4 through 21 to detain data for *received batches* inventory for the appropriate cycle weeks of the month.
26. Click **D3** cell.
27. Click **Data**.
28. Click **Filter**.
29. Click **AutoFilter**.
30. Click the **Batch Returned Date** drop-down list.

The following steps pulls each cycle week's completed batches to determine the *monthly completed inventory*. The report includes data reported by calendar claim cycle dates. Refer to the *Claims Cycle Calendar* for the date ending last month's cycle, to determine the start date for the current month's cycle. Use the same week's dates completed above for the received data.

31. Click **Custom**.
    - In the first drop-down list click **is greater than or equal to**.
    - In the drop-down list to the right of the first, type the **date** of the Sunday date following the last cycle week reported.
    - In the third drop-down list, click **is less than or equal to**.

- In the drop-down list to the right of the third, type the **date** of the following Saturday.
- Click **OK**. If the criterion selected finds a match the rows matching the criteria display. If no rows display, go to step 14.

32. Click the blank cell after the last row of the data in **the # of pieces** column.
33. Click **Auto Sum** on the toolbar.
34. Highlight all the numeric data in column **D**.
35. Press **Enter**.
36. To complete a quality check of *batch compliance*, complete the following steps:
    - View the numbers in the *# of Days* column. If any number is greater than or equal to 21, there must be a number in the **Pieces over 20 days** column.
    - Add the numbers found in the *Pieces over 20 days* column. This is the number of pieces out of compliance. If there are no batches with pieces out of compliance, continue with step 37.
    - Click the blank cell after the last row of the data in the *Pieces over 20 days* column.
    - Click **AutoSum** on the toolbar.
    - Highlight all the numeric data in *Column I*.
    - Press **Enter**.
37. To determine the *weekly average days to complete batches, c*lick the blank cell after the last row of the data in the *Days to Complete Batch* column.
38. Click **fx** on the toolbar.
39. Click **Average.**
40. Highlight all the numeric data in *Column H* and click **OK**.
41. Highlight all the current information shown on the spreadsheet.
42. Click **File**.
43. Click **Print**.
44. Click **Selection**.
45. Click **OK**.
46. Retrieve the printout from the printer and write the cycle dates for that week on top of the page.
47. Delete the sum calculation at the end of the *# of pieces* column and delete the average calculation in the *Days to Complete Batch* column.
48. Click the **Batch Date** drop-down list and click **ALL**. This unfilters the spreadsheet data, and returns the spreadsheet data to the column. Repeat steps 22 through 41 until each weeks completed batches inventory data is pulled for the appropriate cycle weeks of the month.
49. Click **File**.
50. Click **Close**.
51. Click **No**.

Completing Month End Worksheet

After pulling the completed batches inventory for each cycle week, record this data in the month-end worksheet. Complete the following steps:

1. Click **Open**. Locate the file from directory path *L:\Package Three\TPL\Health\Retroxls\TPC6,11\Month00Tpl.xls*. Open the last month's report. Delete the previous information and type in the current month's information.
2. Click the **Sheet 1** tab.
3. Click **File**.
4. Click **Save As** and save as the current month spreadsheet *Month00Tpl.xls*.
5. Type the cycle dates for the current month in *Column A* of the *Weekly Inventory* table. The week date is the Saturday (or last day) date of the week. If there is a five-week cycle add another row above the total row. Highlight the entire *Total* row then right-click and click **Insert** to insert a row. Insert the additional row above the *Total* row. If it is a four-week cycle month and five weeks are displayed delete a row from the table. Highlight the row above the *Total* row, then right-click and click **Delete**.
6. Delete the prior month's data in *Column B, C, and D* only above the *Total* row.
7. Type the ending inventory as this month beginning inventory in the *Month End Report Data* table.
8. Type in each week's data from the printouts in the appropriate *Columns Received, Completed*, and *Average Days to Complete*. Drag the calculation in Column E to the last row added. The table is set up to automatically calculate the month's total. The spreadsheet formulas calculate the received, completed, and ending inventory. Ending inventory in the *Month End Report Data* table should match the ending inventory of the last cycle week reported.
9. Click **Beginning Inventory** in *the Reference Table*.
10. Type the new beginning inventory from the *Month End Report* table on the formula bar.
11. Click **Ending Inventory** in the *Reference Table*.
12. Type the new calculated ending inventory from the *Month End Report Data* table in the formula bar.

The next steps are for completing the Microsoft Excel workbook file.

Calculating the Monthly Average Days to Complete Batches

13. Click **Sheet 2** of spreadsheet workbook.
14. Click **Cell C1** and change the date to the current month.
15. Delete the previous month's numeric data.
16. Type the number of days to complete from the *Average Days to Complete Batch* column on the printouts data from Step 39, then perform the following calculation:
17. Click the empty cell below the last numeric data entry.
18. Click ***fx*** on the toolbar.
19. Click **Average**.
20. Click **OK**.
21. Highlight all numeric data in *Column A*.
22. Click **OK**. This calculates the average days to complete the requests for the month selected.
23. Click **File**.
24. Click **Print**.

25. Click **Entire workbook** in the *Print what* section.
26. Click **OK**.
27. Click **Save**.
28. Close Microsoft Excel.
29. Retrieve the printouts from the printer.

Quality Check Outstanding Inventory

The following procedure is used to verify the outstanding inventory number is correct.

1. Open Microsoft Excel.
2. Click **File**.
3. Click **Open**. Open the file from the directory path *L:\Pkg Three\Tpl\Health\HealthBatches\HealthBatches2004.xls.*
4. Highlight the spreadsheet for the dates in *Column C* from the current day through the first day of the current cycle month.
5. Click **File**.
6. Click **Print**.
7. Click **Selection**.
8. Click **OK**.
9. Click **File**.
10. Click **Close**.
11. Click **No**, for **Do Not Save**.
12. Retrieve the printout from the printer.
13. Write *Outstanding Inventory* and the month date on the top of the printout.
14. Mark the location on the printout, in the *Batch Date* column, of the cycle month date ending point for received batches.
15. Verify that *Completed Batches* met the 21-day time frame by reviewing the *Column Days to Complete*.
16. Mark the *Batch Returned Date* and *Review Dates* to find any dates past the cycle end date. Delineate the batches returned within the cycle date. The remaining are outstanding batches.
17. Add the number of pieces of the remaining outstanding batches. This amount should match the number of the ending inventory calculated on the *TPC6, 11.xls* spreadsheet. If inventory does not match, call the supervisor to resolve this issue.

Section 2: Health Insurance Cost Avoidance and Recovery

Overview

As a condition of eligibility for medical assistance, each member assigns their rights to medical support, or third party payments, to the IHCP agency and agrees to cooperate in obtaining payment from primary payers. Each member authorizes insurers to release to the IHCP, on written request, all information needed to secure or enforce the IHCP rights to third party liability.

Third party liability is the legal obligation of individuals, insurance companies, and others responsible for medical expenses incurred by an IHCP member. Federal regulations and state statutes mandate cost-containment by the IHCP.

The IHCP uses the following cost containment methods:

- Cost avoidance
- Cost recovery

Cost Avoidance

Cost avoidance prevents payment of the IHCP claims when a third party is liable for the medical expenses. Examples include private and group health insurance, labor union plans, self-insured plans, trust funds established for payment of medical expenses, and court-ordered medical coverage.

Cost avoidance begins when a member enrolls in the IHCP. The member's county caseworker, providers of service, Indiana*AIM,* and Health Management Systems (HMS) are all involved in the cost avoidance process. HMS is the EDS subcontractor responsible for cost avoidance and health care claims recovery.

On enrollment, or when there is a change to a member's insurance coverage, the caseworker enters the information in ICES. ICES transfers new or modified information to Indiana*AIM* each evening.

Indiana*AIM* uses six edits to compare the health services provided to the member with the health coverage benefits that are available to the member. Services billed to the IHCP covered by a third party deny and the provider must bill the third party. The six TPL edits used are as follows:

- *Edit 2500 – Member covered by Medicare A (no attachment)*
- *Edit 2501 – Member covered by Medicare A (with attachment)*
- *Edit 2502 – Member covered by Medicare B (no attachment)*
- *Edit 2503 – Member covered by Medicare B (with attachment)*
- *Edit 2504 – Member covered by private insurance.* This edit is currently inactive for long-term care.
- *Edit 2505 – Member covered by private insurance.* This edit is currently inactive for long-term care.

Providers contact the TPL Help Desk to update member insurance benefit information. The health analyst takes the information from the caller, contacts the insurance carrier to verify the information, and updates the *IndianaAIM TPL Resource File* with the information. Nightly, an update file is sent from Indiana*AIM* to ICES to coordinate and validate the shared information.

HMS maintains a proprietary *IHCP Member Master File*, a database of IHCP and third party enrollment information. HMS updates the master file from eligibility and resource information received from state agencies with HMS contracts and from data match agreements with commercial insurance carriers. HMS has data match agreements with 80 to 90 percent of the commercial insurance carriers. HMS enhances the basic data matches to insurers with matches to the neighboring states insurer files. These files identify members with supplementary insurance coverage and those with coverage through a non-custodial parent outside the State.

Public Consulting Group (PCG) also provides TPL resource data electronically to update Indiana*AIM* resource information.

Cost Recovery

Cost recovery is the process of identifying claims paid by the IHCP and then seeking reimbursement from the liable third party. HMS identifies the IHCP paid claims and potential third party resources through data supplied by Indiana*AIM* and using the HMS proprietary TPL recovery system. The data is used as follows:

- Commercial Insurance Billing

  HMS matches Medicaid eligibility information to their national insurance database. When other coverage is identified, HMS prepares and submits medical and dental claims, called Medicaid Reclamation claims. Insurance carriers adjudicate the claims and submit the explanation of benefits (EOBs) and checks to a lockbox. HMS processes and posts each check to their accounts receivable system. HMS reports payments received and sends the other insurance information to EDS for members with paid claims.

  The IHCP paid claims are matched to the combined resource files and subjected to a series of edits. Claims targeted for recovery are sent to commercial carriers, Blue Cross and Blue Shield, and TRICARE for payment. An accounts receivable (A/R) record is created for each claim targeted for recovery. As funds are received, the recovered funds are deposited in the State account, and the HMS A/R and management reports are created.

- Medicare A Disallowance

  HMS prepares a listing of claims identifying Medicare coverage after Medicaid paid the claim. Providers are asked to review their listings, bill Medicare and report refunds due Medicaid. When refunds are due, HMS prepares adjustment forms for EDS to recoup the money or processes a refund check. Providers must respond within 60 days.

- Coordinated Disallowance

  HMS prepares a listing of claims when other coverage is identified after Medicaid paid the claim. Providers are asked to review the listing, bill the other insurance and report refunds due Medicaid. Providers must respond within 60 days.

- Provider Self-Audit

  HMS sends a notice to providers asking them to refund any amounts owed to Medicaid via credit balance worksheet. HMS follows up with each provider, collects the worksheets, and processes the adjustments or checks.

Section 3: Health Insurance Premium Payment Program

Overview

Many times, IHCP members do not enroll in available private health insurance or drop existing insurance coverage when the IHCP benefits begin. Coverage by other insurance substantially reduces IHCP expenditures. Congress passed legislation requiring state agencies to purchase, when available and cost effective, employer-base group health insurance for covered IHCP members. This legislation also makes enrollment in the Health Insurance Premium Payment Program (HIPP) a condition of the IHCP members' eligibility. The IHCP members covered under employer-based group health plans are provided payments pursuant to section *3910* of the Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual and in compliance with *Title XIX* of the *Social Security Act, 42 USC Sec. 1396e*.

Identifying potential HIPP cases begins with the caseworker who is the primary point of contact with the IHCP member. The caseworker determines the member's eligibility using the client interview guide questions relating to HIPP. The caseworker receives the completed *State Form 3510*. If the member has available insurance, the caseworker enters the policy information on the *ICES TPL* window. When the interview guide responses indicate a high-cost diagnosis or above-threshold annual medical bills, the caseworker sends the completed *State Form 3510* to the TPL Department. Members with the following types of insurance coverage are exempt from HIPP:

- The policyholder is an absent parent who is court-ordered to maintain the insurance
- The member has Medicare coverage

The TPL Department receives the *State Form 3510* from the county caseworker. The TPL analyst sends a letter to the insured member's employer requesting premium information on the company's letterhead. The TPL analyst verifies that the member is not covered by and has no other type of medical coverage.

The TPL Department determines, case-by-case, if it is cost effective for the IHCP to purchase employer-based group health insurance policies on behalf of the covered IHCP members. The system calculates cost-effectiveness based on a formula approved by the CMS, comparing the annual purchase cost of the policy, including the annual premium, deductible, coinsurance, and the administrative fee per policy), multiplied by a factor of two, against the average annual IHCP expenditure. If the policy covers the condition, and if the anticipated expenditure calculation exceeds the total policy cost, the system determines that it is cost-effective to pay the premiums. The member and caseworker each receive a system-generated letter. If it is not cost-effective to pay the premiums, the county caseworker receives a system-generated letter.

The TPL Department tracks HIPP cases; arranges for payment of HIPP premiums and cost-sharing amounts; and communicates HIPP program-related information to affected members, caseworkers, and insurers. Figure 3.1 charts the process.

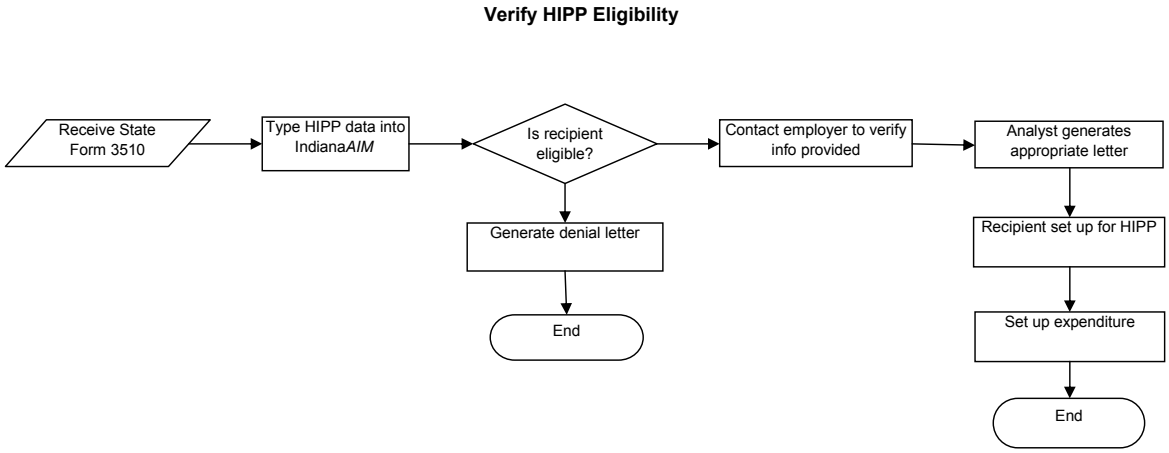

Figure 3.1 – Verification of Eligibility for HIPP

Determine HIPP Eligibility

This procedure verifies the member is currently eligible for the IHCP and is not enrolled in the risked-based managed care (RBMC) program or Medicare. Complete the following steps for each family member:

1. Log in to *IndianaAIM*.
2. Click **Recipient** from the *Main Menu*.
3. Type the HIPP case number in the *Case Number* field.
4. Click **Search**. Each family member appears in the detail window. Highlight the family member.
5 Click **Options**.
5. Click **Eligibility**.
6. Click **Standard**. Verify the eligibility is active. An active eligibility shows an end date of *22991231*. Members without an active eligibility segment are not eligible for HIPP, go to the *Generate Denial* letter procedure. If the member has an active eligibility segment, continue with step 8. As long as one family member is currently eligible for the IHCP, the case number remains on HIPP.
7. Print the window, date, and initial and place in the file. Click **Exit** to return to the *Research* window
8. Click **Options**
9. Click **Medicare**
10. Click **Medicare Coverage.** Verify that the member is not enrolled in Medicare. Medicare members are not eligible for HIPP. If the member is enrolled in Medicare, print the window for the file and go to the Generate Denial Letter procedure.

To continue with the next family member, repeat Steps 6–11.

After verifying the eligibility of all family, the TPL analyst must verify the member's TPL is currently loaded on the *TPL* window in Indiana*AIM*. Use the following steps to verify TPL information:

1. Click **Additional Options** on the *Recipient Search* window.
2. Click **TPL Resource** from the *Member Search* window.
3. Click the current TPL segment showing effective date *2299/12/31*.
4. Click **Select** to open the window.
5. Verify that the *Termination Date* is *2299/12/31,* on the *TPL Detail* window. If the TPL information is not on the resource file, add the TPL Information. Procedures for adding this information are located in Section 3 of this volume.
6. Print a copy of the *TPL Detail* window and place in the file.
7. Click **Exit**.

To complete a letter requesting premium information, use the following steps:

1. Open Microsoft Word.
2. Click **File**
3. Click **Open**. Open the file using the path *L:\Package Three\Tpl\Hipp\Hipp LTRS\HippEmployer.doc*.
4. Type the employer name and address.
5. Type the employee's name in the *RE:* field.
6. Type the member's social security number in *Social Security #:* field.
7. Click **File**.
8. Click **Print**.
9. Type **2** in the *Number of Copies* field to make two copies of the letter.
10. Send one copy to the member's employer and keep one copy for the *TPL Pending HIPP* file.

Update HIPP Information

After the analyst has determined the member's eligibility is active and the member is not enrolled in the RBMC or Medicare programs the information is used to update Indiana*AIM*.

1 Log in to Indiana*AIM*.

2 Click **Third Party Liability** on the *Main Menu*.

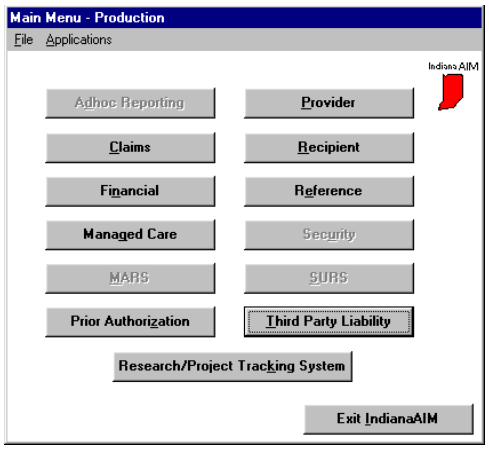

Figure 3.2 – Indiana*AIM* Main Menu Window

3 Click **Search/Resource** on the *TPL Menu*

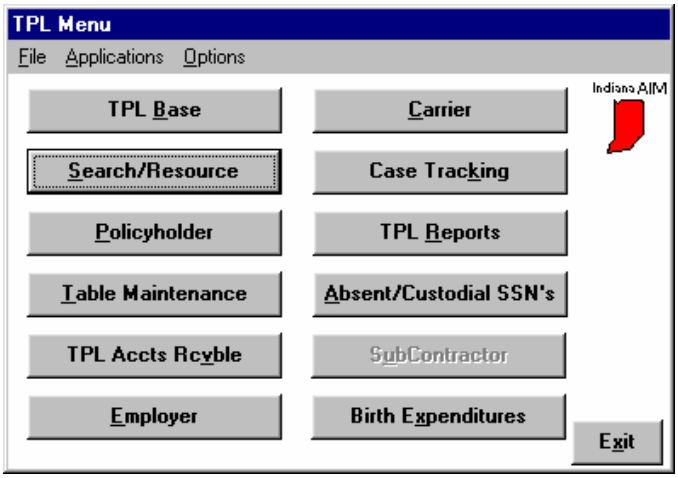

Figure 3.3 – TPL Main Menu Window

4. Click **Options**.

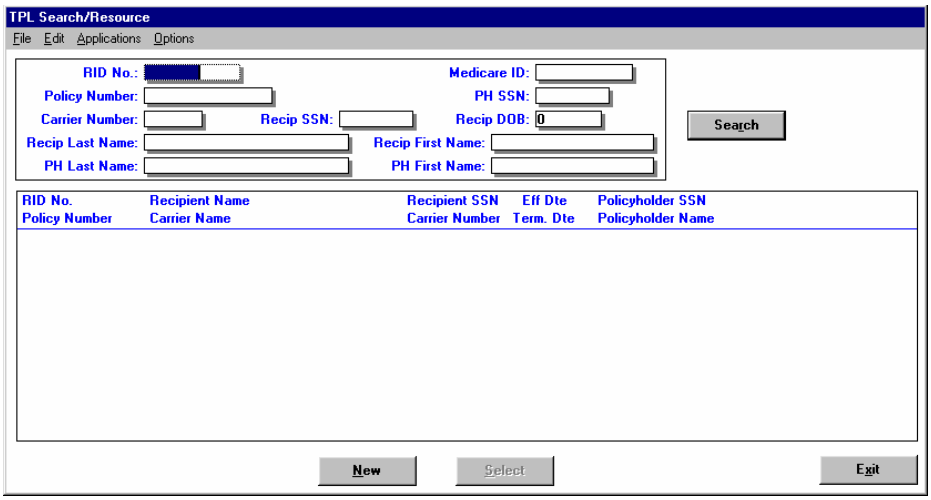

Figure 3.4 – TPL Search/Resource Window

5. At the drop-down menu click **HIPP Search**.

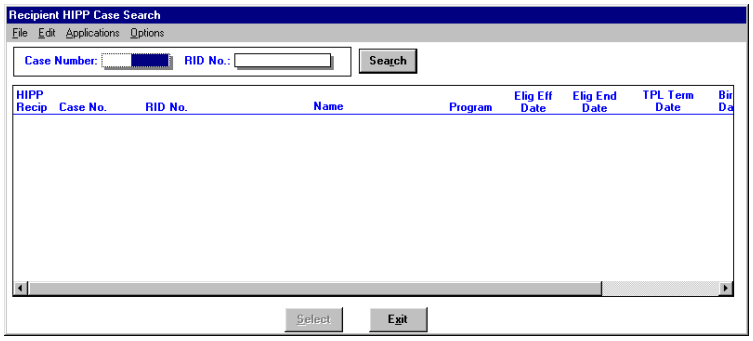

Figure 3.5 – Member HIPP Case Search Window

6. Type the case number in the *Case Numbe*r field.
7. Click **Search**.

8. Click **Select**.

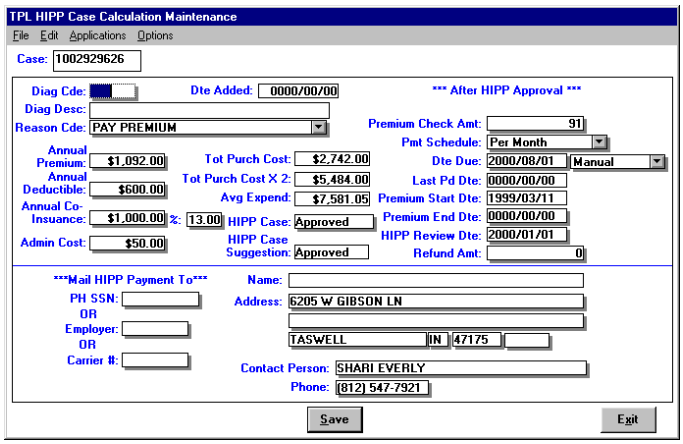

Figure 3.6 – TPL HIPP Case Calculation Maintenance Window

9. If entering a member in HIPP, pending information from the employer, continue with Step 10. Go to Step 15 to enter information from the employer and enter member in HIPP for approval.
10. Click the **Reason Code** drop-down arrow.
11. Click **Pending Verification**. One month premium amount multiplied by 12 equals the annual premium. One week premium amount multiplied by 52 equals the annual premium.
12. Click **Save**.
13. Exit Windows.
14. Go to the procedure *Send Request Letter for Premium Information*.
15. Type premium information from the employer's information received on the company's letterhead in the fields on the *Premium* window. This information includes the annual premium, deductible, and coinsurance percentage.
16. Click **Save**.

17. Click **Options**.

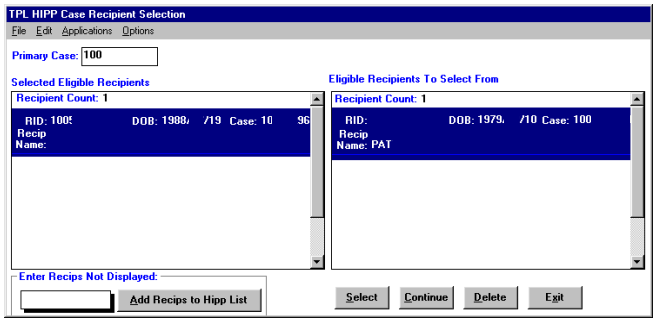

Figure 3.7 – TPL HIPP Case Member Selection Window

18. Click Add Recipients to HIPP List.
19. Click Select.
20. Click Continue.

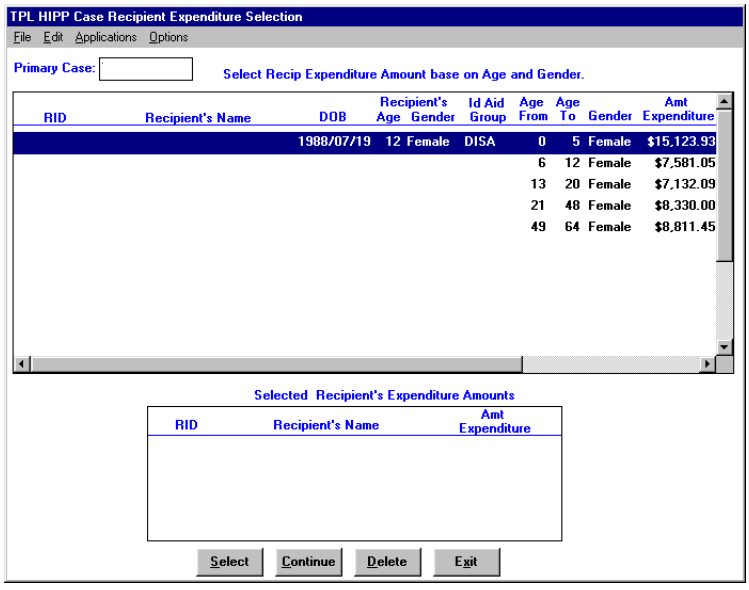

Figure 3.8 – TPL HIPP Case Member Expenditure Selection Window

21. Click **Options**
22. Click Calc Avg Expend.
23. Select a family member by highlighting the age range in accordance with the date of birth.
24. Click **Select**. The annual expenditure dollars based on member Age and Aid Category displays in the detail window and automatically populates the *Avg Expend* field on the *TPL HIPP Case Calculation Maintenance* window.
25. Click **Continue**.
26. Click **OK**.
27. Click Click **Save.** Indiana*AIM* indicates approval or denial. If the total purchase cost is less than the *Amt of Avg Expend*, the HIPP is approved. If the total cost is greater than the *Amt of Avg Expend*, the HIPP is denied.

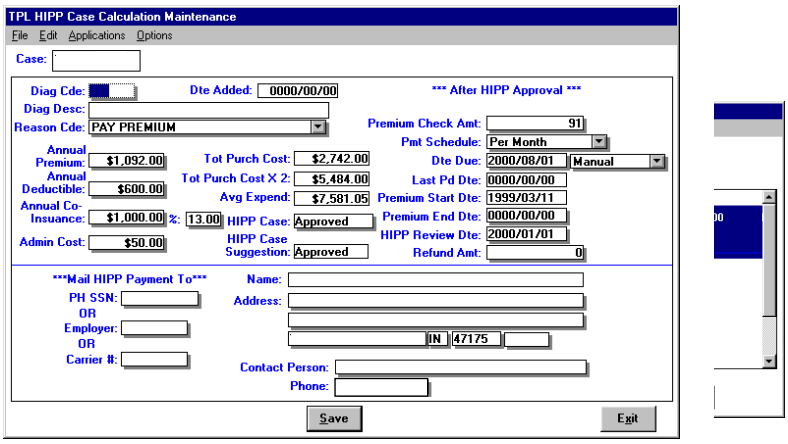

Figure 3.9 – TPL HIPP Case Calculation Maintenance Window

28. Review the HIPP Case Suggestion field for system approval or denial.
29. For approvals, go to the procedure for generating a *HIPP Eligibility Letter*. For denials, go to the procedure for generating a *HIPP Denial Letter*.
30. For approvals when the member is not enrolled in the health plan, go to the procedure for sending the *HIPP Enrollment Notice*.

If the member is eligible for HIPP but not enrolled, the analyst sends a letter notifying the member that enrollment in HIPP is a condition of eligibility and that the member has 10 days to enroll. The caseworker receives a copy of the letter. If the member does not enroll in HIPP, subject to the member's appeal rights, the local Office of County Division of Family and Children terminates the IHCP benefits. When a member fails to enroll children in HIPP as a condition of eligibility, only the adult member loses the IHCP eligibility. The children's benefits are not terminated.

HIPP Denial Letter

1. Open Microsoft Word.
2. Click **File**. Open file from the path *L:\Package Three\TPL\HIPP\HippLTRS\Hipp Not Cost Effective.doc.*
3. Type the address of appropriate county.
4. Type the caseworker's name in the *ATTN:* field.
5. Type the member's name in *RE:* field.
6. Type the case number in the *Case #* field.
7. Type the caseworker's name after *Dear*.
8. Click **File**.
9. Click **Print**.
10. Type **2** in the Number of copies: field to make two copies.
11. Click **OK**.
12. Retrieve copies of letters from the printer.
13. Click **File**.
14. Exit Microsoft Word.
15. Send one letter to caseworker and keep one copy for TPL HIPP denied case file.

HIPP Eligibility Letter

Use the following steps to generate a *HIPP Eligibility Letter*. The policyholder and the caseworker receive the *HIPP Eligibility Letter* when the member receives HIPP approval.

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file from the following directory: *L:\Package Three\TPL\HIPP LTRS\HIPP Eligibility Letter.doc*.
4. Type the name of policyholder or caseworker.
5. Type the policyholder's or caseworker's address in the *Address:* field.
6. Type the city, state, and ZIP Code in the *City, State, ZIP* field.
7. Type the policyholder's name and IHCP number **i**n the *Policyholder* field.
8. Type the name of policyholder or caseworker in the *Dear:* field.
9. Type the policyholder's name in the *Policyholde*r field.
10. 1Type the group number in the *Group N*umber field.
11. Type the employer name in the *Employer* field.
12. Type the name of the insurance company in the *Insurer* field.
13. Type the name of the eligible IHCP member in the *RE:* field.
14. Type the month the reimbursements are scheduled to begin in the body of letter after *Beginning*.
15. .Type the period the disbursement covers, for instance, July 1, 2000, through July 31, 2000.

16. Type the amount of the check.
17. Type the analyst's extension.
18. Type the analyst's name.

HIPP Enrollment Notice Letter

The following letter is sent to the policyholder and employer when the HIPP has been determined as cost effective and approved; however, the member or policyholder has not enrolled in the health plan.

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file from the following directory: *L:\Package Three\TPL\HIPP LTRS\HIPP Enrollment Notice.doc*.
4. Type the name of policyholder or employer in the appropriate field.
5. Type the policyholder's address or employer's address in the *Address* field.
6. Type the city, state, and ZIP Code in the *City, State, ZIP* field.
7. Type the policyholder's name in the *Policyholder* field.
8. Type the group number in the *Group Number* field.
9. Type the employer name in the *Employer* field.
10. Type the insurance company name in the *Insurer* field.
11. Type all eligible IHCP members in the *Persons Required to Enroll* field.
12. Type the policyholder's name in the *Dear* field.
13. Type the analyst's name.

HIPP Member Monthly Eligibility Verification

Each month the TPL analyst must verify that current HIPP members are still eligible by verifying they are eligible for the IHCP and not enrolled in the RBMC program or Medicare. Use the following steps to verify TPL and eligibility:

1. Gather all current HIPP member files.
2. Log on to Indiana*AIM*.
3. Click **Recipient** from the *Main Menu*.
4. Type the HIPP case number in the *Case Number* field.
5. Click **Search**. Each family member appears in the detail window. Highlight the family member.
6. Click **Options**.
7. Click **Eligibility**.
8. Click **Standard**. Verify that the eligibility is currently active. An active eligibility has an end date of 22991231. If member does not have an active eligibility segment, the member is not eligible for HIPP. Go to the procedure *Generate Denial* letter. If the member has an active eligibility segment,

continue. As long as one family member is currently eligible for IHCP, the case number remains on HIPP.

9. Exit the *Eligibility* window.
10. Click **Options**.
11. Click **PMP Assignment**. Check for RBMC enrollment. RBMC members are not eligible for HIPP. If this is true for the member, print a copy of the window for the file, and go to the procedure, *Generate A Denial* letter. Otherwise, continue.
12. Click **Exit**.
13. Click **Options**.
14. Click **Medicare**.
15. Click **Medicare Coverage**. Check for Medicare enrollment. Medicare members are not eligible for HIPP. If this is true for the member, print a copy of the window for the file, and go to the procedure, *Generate a Denial Letter*. Otherwise, continue.
16. Complete steps steps 6 through 16 for each family member. After verifying all family members, complete the procedures for verifying active TPL coverage.

HIPP Member Monthly TPL Verification

After verification of the HIPP member's eligibility, the TPL analyst verifies that TPL information is loaded on the *TPL* window in Indiana*AIM*.

1. Click Applications.
2. Click Third Party Liability from the *Member Search* window.
3. Click Search/Resource on the *TPL Menu*.
4. Type the RID number in the *RID Number* field.
5. Click Search.
6. Click the active TPL segment. An active TPL segment shows an end date of 2299/12/31.
7. Click Select. Verify the termination date is *2299/12/31*, on the *TPL Detail* window. Repeat these steps for each family member to verify current TPL information.
8. If the TPL is not active the health analyst calls the insurance carrier to verify the policy terminated. If the insurance carrier verifies the policy as terminated, the analyst goes to the procedure for terminating the HIPP.
9. If the insurance carrier states the policy reinstated, the health analyst updates the TPL Resource File with the TPL information from the carrier.
10. The health analyst calls the employer to request the premium information, on the company's letterhead, to verify that the premium information had not changed during the time of the lapsed policy.
11. If the premium information did change, the health analyst goes to the procedures for entering HIPP approval or approval pending receipt of the policy premium information.

Expenditure Procedures

Complete the following expenditure procedures *after* the TPL analyst completes the *HIPP Monthly Verification of Members TPL and Eligibility* procedure on the last business week of the month. This procedure generates the expenditure request for the EDS Finance Unit to generate the checks for the HIPP premium payment. The expenditure process is as follows:

1. Open Microsoft Word.
2. Click **File**.
3. Click **Open**. Open the file from the following path: *L:\Package Three\TPL\HIPP\HIPPxls\Expend.doc*.
4. Click **Mail Merge**.
5. Click **Merge**
6. Type the date for the current month in *Justification* field.
7. Go to the next page.
8. Repeat steps 6 and 7 for each page of the document.
9. Click **File**.
10. Click **Print**.
11. Click **OK**.
12. Retrieve copies of the expenditure documents from the printer.
13. Log in to Indiana*AIM*.
14. Click **Financial** from the *Main Menu*.

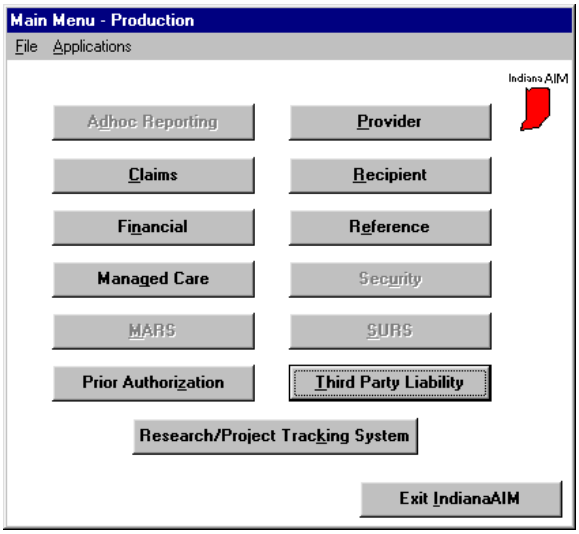

Figure 3.10 – Indiana*AIM* Main Menu Window

15. Click Expenditure TXNs.

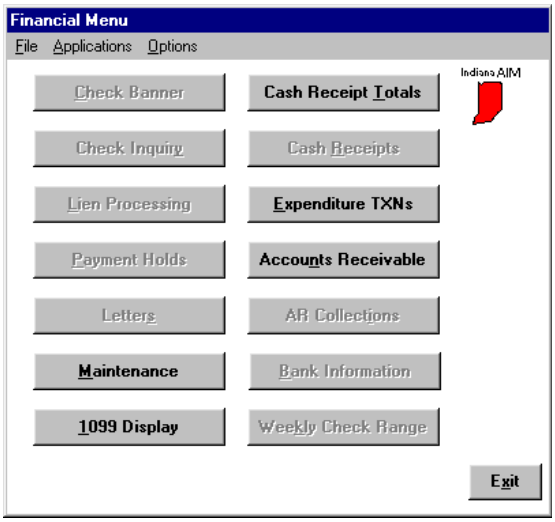

Figure 3.11 – Financial Menu Window

16. Click **New**.

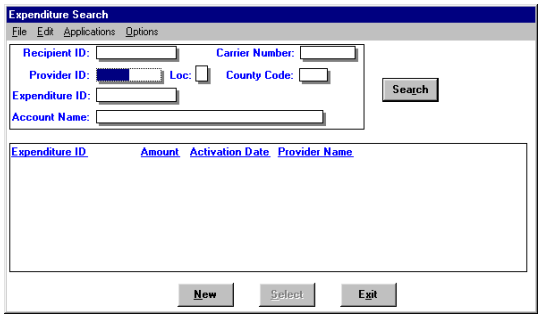

Figure 3.12 – Expenditure Search Window

17. Click *Payee Code* **O** for *Other*.

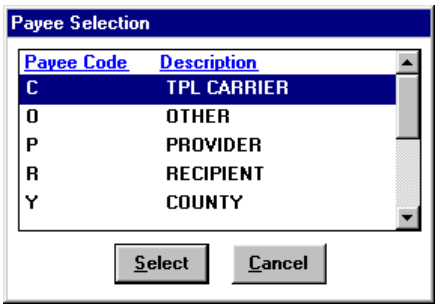

Figure 3.13 – Payee Selection Window

18. Click **Select**.
19. Type the payee name and address in the appropriate fields. This is the member, policyholder, the employer, or carrier. In most cases, the employer automatically deducts the premium from the policyholder's paycheck and issues payment to the policyholder.

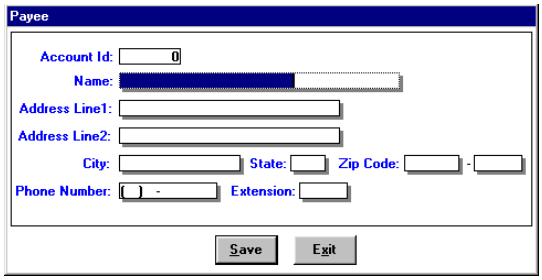

Figure 3.14 – Payee Window

20. Click **Save**.
21. Click **Exit**.
22. Type the check amount in the *Amount Paid* field.

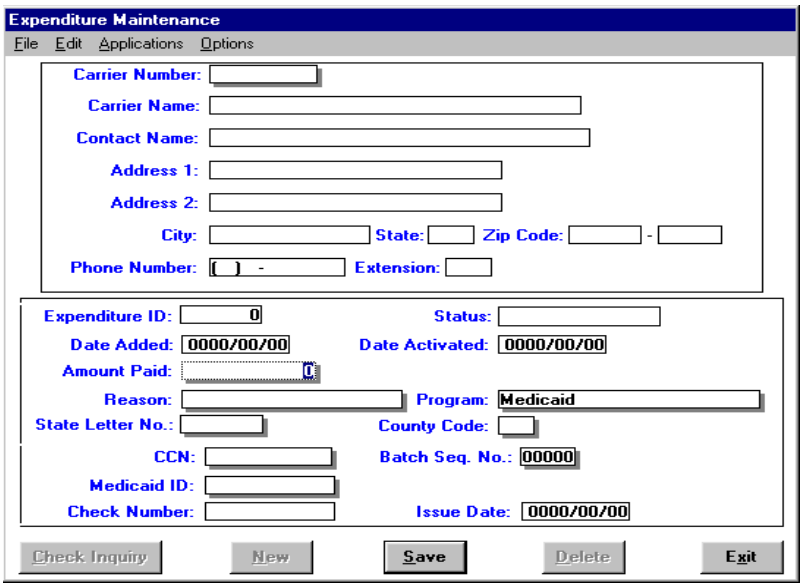

Figure 3.15 – Expenditure Window

23. Click **Reason** and **HIPP SYS** from the drop-down list.
24. Type today's date as MMDD, without the year, in the *State Letter No.* field.
25. Type the member's RID number in the *Medicaid ID* field.
26. Click **Save**. The system autopopulates the **Expenditure ID** field with an expenditure number.
27. Type the expenditure ID number in the *Expenditure Number* field on the *Expenditure Payout Request* form.
28. Click **Exit**.
29. Repeat steps 16–30 for each approved HIPP member or policyholder.
30. Take the expenditure payout requests to the TPL supervisor for approval and signature.
31. Make one copy for the TPL file after receiving the expenditure approval from the supervisor.
32. Take the original expenditure request to the Finance Unit. Finance brings the checks to the TPL Unit the following Tuesday.
33. Open Microsoft Word and click **File**.
34. Click **Open**. Open the file using the following directory: *L:\Package Three\TPL\HIPP\HIPPLTRS\HIPP Payment.doc*.
35. Type the address corresponding to the individual or entity receiving the check. This can be the member, policyholder, employer, or carrier. In most cases the employer automatically deducts the premium from the insured policyholder's paycheck and issues payment to the policyholder.
36. Type the name of insured member after the *RE:* field.
37. Type the dates covered by the paid amount in the *Date* field in the first paragraph.
38. Type the health analyst's name.

39. Click **File**.
40. Click **Print**.
41. Make one copy of each check, letter, and *Expenditure Payout Request* form.
42. Send the letter with check to appropriate address.
43. File copies in the TPL file.

Premium Payments for Nonmembers

Federal law requires the IHCP to pay premiums and cost-sharing obligations when cost-effective, including those paid for by a nonmember, except for an absent parent. The IHCP pays the premiums that cover both the member *and* other family members who are *not* IHCP members. The IHCP will not pay for noncovered services. The IHCP pays only the amount in excess of the insurance payment up to the IHCP allowed amount for the member. It will not pay for family members who are not IHCP members. If any party, member or nonmember, *voluntarily* chooses to continue paying employer-based plan premiums and cost-sharing obligations, the IHCP will not assume the payments. The IHCP cannot force an IHCP member, or a nonmember acting on behalf of an IHCP member, to accept the State's assistance with payment of employer-based insurance costs. Monthly reviews ensure the policy remains in force. If the payer stops paying the premiums, cost-effectiveness is reviewed, and if the paying the premium for the policy is still cost-effective, follow-up is determined on a case-by-case basis.

Insurance Payments to Other Entities

After EDS begins HIPP premium payments, the insurer must pay the provider of service, or reimburse the IHCP if a claim does not deny for TPL when processed by the IHCP. As with other third party liability, insurers must not pay the policyholder for services rendered by the IHCP providers or paid by the IHCP, in accordance with federal and state laws. If the policyholder is the member and the member is receiving the insurance benefits, EDS notifies the member of his or her obligation to forward the insurance benefit payments to the IHCP. If the member fails to send TPL payments within 30 days following receipt of the demand letter, the caseworker receives notice of the member's failure to comply. The caseworker follows the procedure for discontinuing the IHCP benefits. The member receives ten days advance notice of termination of premium payments.

Electronic Rosters or Premiums

The member, policyholder, or employer receives, by mail, a manual check each month. The carrier, employer, or policyholder requesting the premium, or a list of enrollees electronically, are directed to the IHCP Web site at www.indianamedicaid.com to complete the trading partner agreement and profile for receiving electronic transactions.

Tracking HIPP Processes

The health analyst uses the following spreadsheets to track information about the HIPP process. All of the information tracked is compiled monthly with the *Monthly Activity Report* procedure.

HIPP Daily Activity

The *HIPP Daily Activity Spreadsheet* monitors HIPP transactions worked by the analyst each day. The spreadsheet provides information for the monthly *HIPP Activity Report*. Information tracked is as follows:

- *Column A*: Date HIPP Requests were reviewed
- *Column B*: Amount of new HIPP requests reviewed that were not cost effective
- *Column C*: Amount of new HIPP requests reviewed that were approved
- *Column D:* Amount of new HIPP requests reviewed that are pending additional information
- *Column E*: Amount of already pending HIPP requests that have been approved
- *Column F:* Amount of already pending HIPP requests that are not cost effective
- *Column G:* Total of each column

Pending HIPP

The *Pending HIPP* spreadsheet tracks additional information requested from the employer. Information tracked is as follows:

- *Column A*: Names of policyholders and case numbers
- *Column B*: Date request for additional information was sent
- *Column C*: To whom correspondence was sent
- *Column D:* Date follow-up was made on request sent
- *Column E:* Date HIPP denied for noncompliance if requested information is not received in 60-days

HIPP Non-compliance

The *HIPP Non-compliance* spreadsheet tracks HIPP applicants for *60-day no response* compliance. Information tracked is as follows:

- *Column A*: Date applicant was denied
- *Column B*: Policyholder name
- *Column C*: Case number
- *Column D*: Date correspondence for additional information was sent
- *Column E:* To whom correspondence was sent

HIPP Spreadsheet

The *HIPP* spreadsheet provides active HIPP case activity. The spreadsheet is comprised of two sections.

The top portion of the spreadsheet contains the following:

- *Column A*: Policyholder name, case number
- *Column B*: Amount of HIPP check disbursed and total

- *Column C*: Date HIPP case premium information due to be re-verified for accuracy
- *Column D:* Outcome of reverification information received
- *Column E*: Date family first became eligible for HIPP

The lower portion of spreadsheet contains the following:

- *Column A*: HIPP members who have been discontinued
- *Column D*: Date case was verified not cost effective
- *Column E:* Reason for terminating from HIPP

HIPP Monthly Activity Report

The TPL analyst generates the *HIPP Monthly Activity Report* at the end of each month for reporting to the IHCP.

1. Open Microsoft Word.
2. Click **File** and highlight the file at directory path *L:\Package Three\TPL\HIPP\HIPPLTRS\Hippact2.doc*.
3. Click **Open**.
4. Change the month to the current month.
5. Open Microsoft Excel. The user must switch between Microsoft Word and Excel documents during this process.
6. Click **File** and highlight the file at directory path *L:\Package Three\TPL\HIPP\HIPP Spreadsheets\Hipp Verifications.xls.*.
7. Click **Open**.
8. Add the numbers in *Columns B, C*, and *D*, corresponding *to Column A* for the appropriate month and date row. The figure represents total number of new HIPP requests received from county offices for the current month.
9. Click ***Hippact2.doc*** and type the total of new HIPP requests received from county offices on the *Monthly HIPP Activity Report*.
10. Click ***HIPP Verification.xls***
11. Type the amount in the *New Approved* column for the appropriate month and date.
12. Click ***Hippact2.doc*** and type the number from Step 11 corresponding to the number in Column A – *Cost Effective:* under *New HIPP Requests Received from County Offices*.
13. Click ***HIPP Verification.xls.***
14. Type the amount in the *New NCE* column for the appropriate month and date.
15. Click ***Hippact2.doc*** and type the number from Step 14 corresponding to the number in Column B – *Not Cost Effective* under *New HIPP Requests Received from County Offices*.
16. Click ***HIPP Verification.xls***.
17. Type he amount in the *New Pending* column for the appropriate month and date.
18. Click ***Hippact2.doc*** and type the number from Step 17 corresponding to Column C – # *Pended for Additional Information* under *New HIPP Requests Received from County Offices*.

19. Click **File** in Microsoft Excel. Locate and highlight the file at directory path *L:\Package Three\TPL\HIPP\HIPP Spreadsheets\Pending.xls.*
20. Click **Open**.
21. Count the number of individuals listed on the *Pending* spreadsheet.
22. Click ***Hippact2.doc*** and type the number from Step 21 corresponding to the *Pending Inventory*.
23. Click **Window**.
24. Click ***HIPP Verification.xls***.
25. Type the number in the *Pending Approved* column for the appropriate month and date.
26. Click **Hippact2.doc**.
27. Type the number from Step 25 corresponding to Column D – # *Cost Effective* listed under *Pending Inventory*.
28. Click **HIPP Verification.xls**.
29. Type the number in the *Pending NCE* column for the appropriate month and date.
30. Click **Hippact2.doc**.
31. Type the number from Step 29 corresponding to Column E – # *Not Cost Effective under Pending Inventory*.
32. Subtract the # *Cost Effective* from the # *Not Cost Effective* in the number of *Pending Inventory* to obtain a total.
33. Type the total from Step 32 corresponding to Column F – # *Still Pending for Additional Information* under *Pending Inventory*.
34. Open Microsoft Excel.
35. Click File. Locate and highlight the file at directory path *L:\Package Three\TPL\HIPP\HIPP Spreadsheets\Active Cases.xls*.
36. Click **Open**.
37. Count the number of cases noted as noncompliant, in the Re-Verification Approved column for the appropriate month and date.
38. Click ***Hippact2.doc***.
39. Type the number of noncompliant cases from Step 37 corresponding to Column G – # *Purged (Non-Compliance) under Pending Inventory*.
40. Complete the following calculation: # *Pending for Additional Information* plus # *Still Pending for Additional Information* minus # *Purged (Non-Compliance) = Total*.
41. Type the total from Step 40 corresponding to the End of Month Pending Cases.
42. Get a copy of the previous Monthly HIPP Activity Report.
43. Type the number from the # *Cost Effective Cases End of the Month* from the previous *Monthly HIPP Activity Report* corresponding month beginning cost effective cases on the *Hippact2.doc*.
44. Click ***HIPP Verification.xls***.
45. Count the number of cases in the *New Approved* column for the appropriate month and date.
46. Click ***Hippact2.doc***.
47. Type the count from Step 45 corresponding to # *New Cost Effective Cases*.

48. Click Active Cases.xls.
49. Count the number of cases listed under Discontinued HIPP Members in Column A at the bottom of the page.
50. Click Hippact2.doc.
51. Type the count from Step 49 corresponding to the # Cases No Longer Cost Effective.
52. Complete the following calculation: Month Beginning Cost Effective Cases plus # New Cost Effective Cases minus #Cases No Longer Cost Effective = Total.
53. Type the total from Step 52 corresponding to # Cost Effective Cases-End of the Month.
54. Click the Active Cases.xls file to find the total dollars paid under Monthly Check Amount column.
55. Click the Hippact2.doc.
56. Type the total dollar amount from Step 53 corresponding to Total Payments Processed.
57. Click Save.
58. Click File.
59. Click Print.
60. Click OK.
61. Retrieve the copy of the report from the printer.
62. E-mail Hippact2.doc to the TPL supervisor.
63. File the hardcopy of report in the TPL HIPP file.

Section 4: Birth Expenditures

Overview

The Third Party Liability Department is required to provide birth related expenditures paid by the IHCP to county caseworkers and prosecutors when requested. In accordance with the *Indiana Code 31-14-17-1*, the expenditures include claims paid for prenatal care, delivery, hospitalization, and postnatal care for the mother and baby.

The county prosecutor uses birth expenditures to determine the cost of the birth related to paternity cases. Birth expenditures provide the total dollar amount of claims paid by the IHCP for the mother and baby for the requested time period.

Procedures

The county prosecutors submit *Requests for Medicaid Pregnancy and Birth Expenditures Request* forms by mail or e-mail to the TPL Department. Figure 4.1 shows a sample copy of the request form.

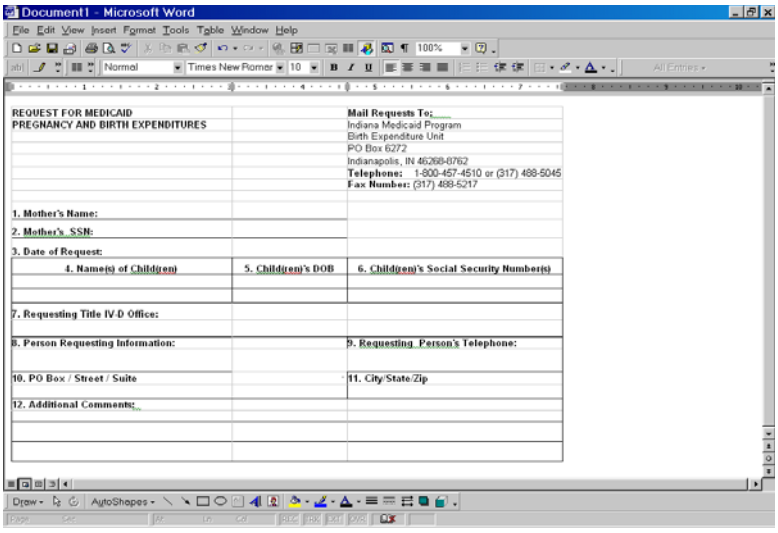

Figure 4.1 – Birth Expenditure Request

On receipt, the health analyst types the request into an Excel spreadsheet stored at the directory path *L:/Package Three/Casualty/Birth Expenditures/Birth Expenditure Report/Birth Expenditure Report YYYY*. After determining the total claim amount the analyst sends a letter and summary report to the requestor.

Steps for locating and updating the spreadsheet for birth expenditure requests are as follows:

1. Open Microsoft Excel.
2. Click **File** and **Open**.
3. Click the drop-down arrow in the *Look In* field. Double click the **L**: drive. The L: drive is the shared departmental drive used by the TPL Department.
4. Click **Package Three**.
5. Click **Casualty**.
6. Click **Birth Expenditures**.
7. Click the **Birth Expenditure Report YYYY** for the appropriate year.
8. Click the tab for the appropriate month.
9. Click the next available line. Copy and insert additional lines as necessary. Figure 4.2 is an example of the birth expenditure spreadsheet.

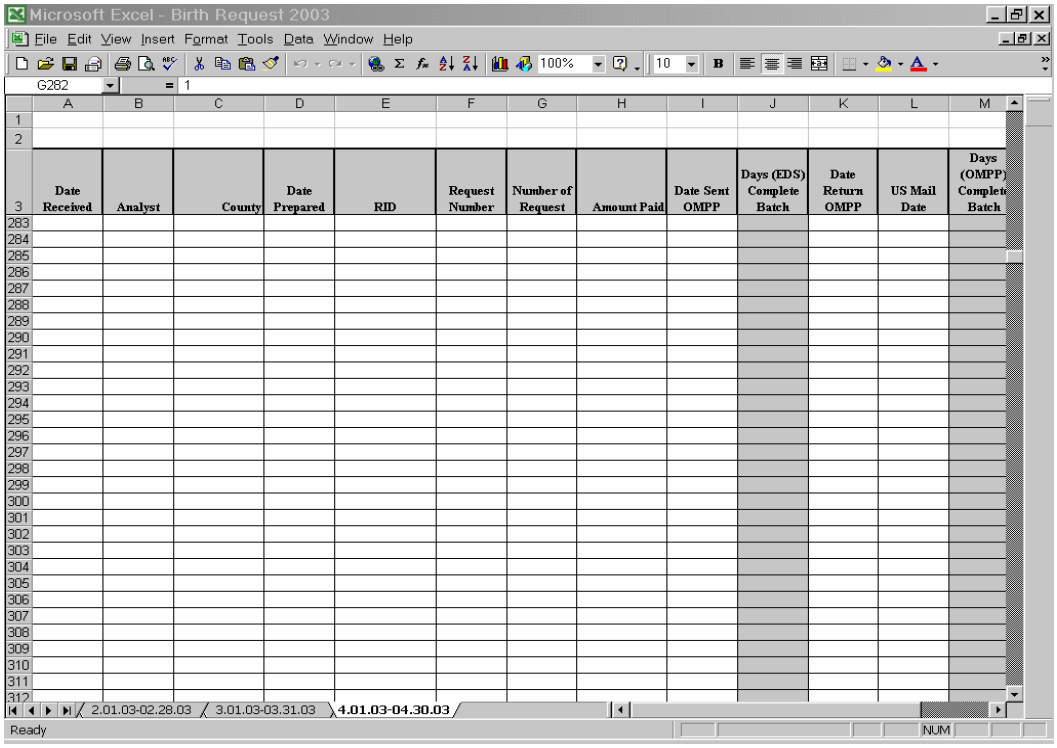

Figure 4.2 – Birth Expenditure Spreadsheet

1. To copy one row or multiple rows, highlight the row numbers, right click and click **copy**.
2. Right click and click **Insert Copied Cells**. If there is no data in the copied fields go to Step 12. If there is data is in the copied rows click off of the highlighted cells and highlight *Date Received*, *Analyst*, *County, RID*, *Request Number*, *Amount Paid*, *Date Sent OMPP*, *Date Return OMPP*, and *US Mail Date*. On the toolbar, press **Delete** to clear the fields.
3. Click the next available line and type the date received, county, and RID number from the request.

4. Click **File** and **Save**.
5. Click **File** and **Close.**

Extracting Claim Information from interChange

The analyst must extract claims data from the Web interChange to provide the county prosecutor or caseworker with pregnancy and newborn related expenses. Indiana*AIM* stores seven years of paid claims data. The analyst only provides fee-for-service claims data to the requestor.

All letters and reports are batch processed and printed at the end of each day and retrieved from the Operations Department by 8 a.m. the following morning.

Use the following steps to extract claims information from Web interChange:

1. Click the **interChange** icon on the desktop.
2. The EDS interChange home page displays.
3. Click **Logon** from the navigation bar on the left side of the screen. The EDS interChange logon page displays.

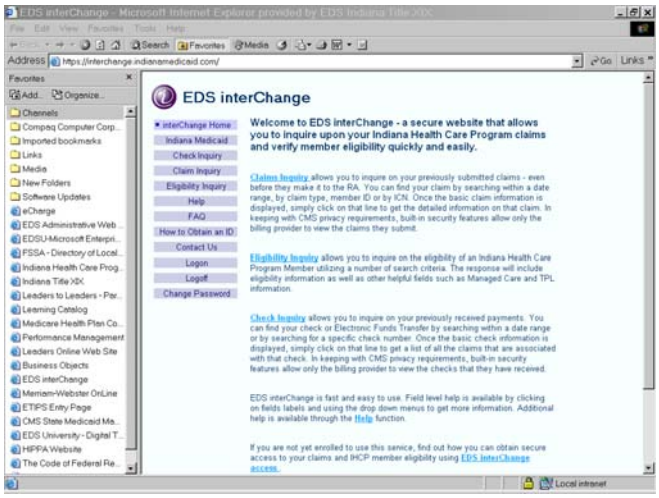

Figure 4.3 – EDS interChange Main Page

1. Type the interChange user ID in the *Provider Number* field.
2. Type the password in the *Password* field.
3. Click **Sign In** button. After verification of the user's ID and password, the interChange home page displays.

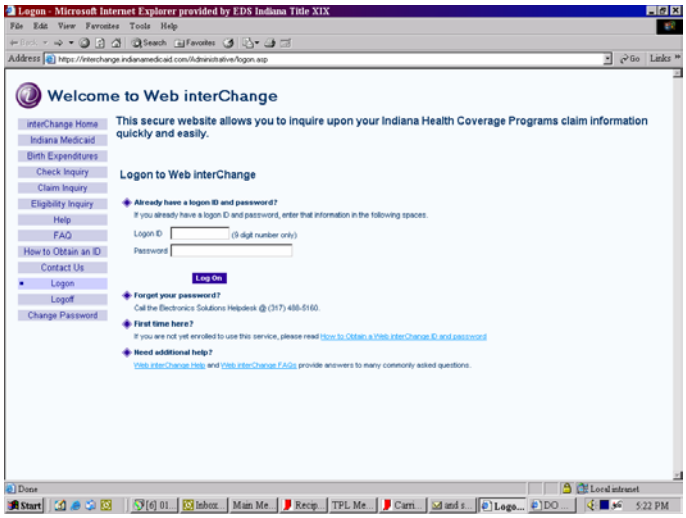

Figure 4.4 – interChange Logon Window

4. Click Birth Expenditure Inquiry.

The following fields are required in the *Query Information* field of the window for a mother's request:

- Mother's member ID (RID) or Social Security number (SSN), the *Search Criteria* drop-down box selections are RID or SSN.
- First and last name of mother
- Child's date of birth. Use the child's date of birth (DOB) to extract paid birth expenditure claims 10 months before and two months after the DOB. A mother's request requires the child's DOB for completion.

The following fields are required in the *Query Information* field of the window for a child's request:

- Child's RID or SSN, the *Search Criteria* drop-down box selections are RID or by SSN.
- First and last name of child
- Child's date of birth. To process this request, the child's date of birth (DOB) is used to extract paid birth expenditure claims 10 months before and two months after the date of birth (DOB).

The following information about the requestor is required:

- First and last name of requester
- County name
- Area code and telephone number
- Street address or P.O. box number
- City, state, and ZIP code

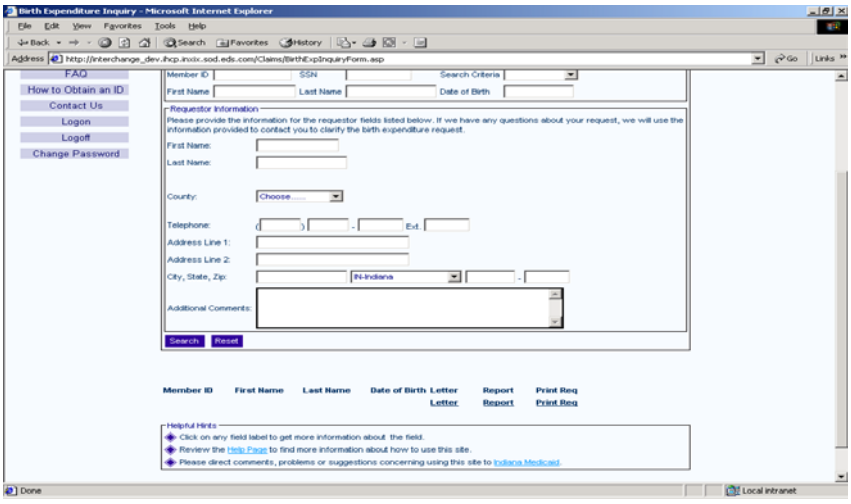

Figure 4.5 – Birth Expenditure Inquiry Window

5. Click the county from the drop-down box. The county prosecutor information automatically populates the telephone number, address lines, city, state, and ZIP code fields. If the information retrieved is not correct, retype the information.
6. Click **Search**. The search results appear on the lower portion of the screen below the *Search* and *Reset* buttons. Scroll down the screen to view the search results.
7. To view the member's *Birth Expenditure* letter, click **Letter**. Generate the following types of letters for a birth expenditure request.
    - *Paid Claims* letter when the member had paid birth expenditure claims. This letter provides the IHCP paid amount.
    - *No Paid Claims* letter when the member did not have paid birth expenditure claims or when the member is not on file in Indiana*AIM*.
    - *Risk-Based Managed Care (RBMC)* letter when the member was enrolled in RBMC during the date range for birth expenditure claims. The RBMC name appears in the letter.
8. Click **Report** to view the member's birth expenditure detail report. The report displays only when the member has paid birth expenditure claims.

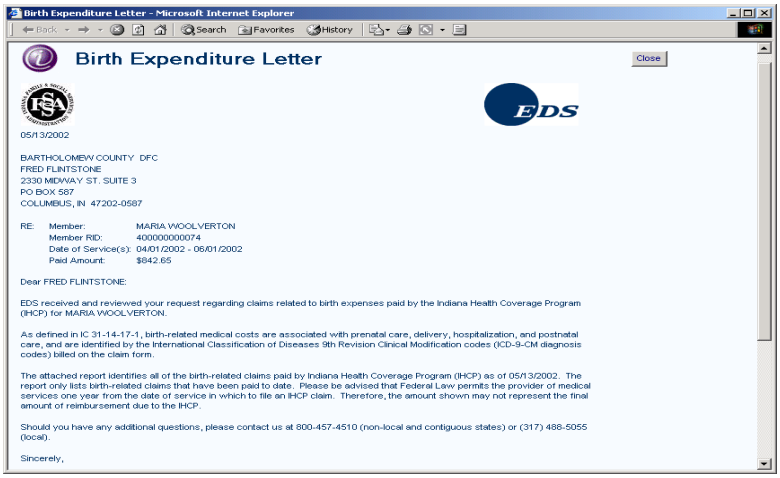

Figure 4.6 – Birth Expenditure Letter Window

9. To create a hardcopy click the **Print Req** option. This saves the birth expenditure request and displays a confirmation page listing the request number. The birth expenditure documents are generated in batches Monday through Friday. The TPL supervisor receives the batches. Click the **Print Req** link *only to generate batches* of hardcopy birth expenditure documents.

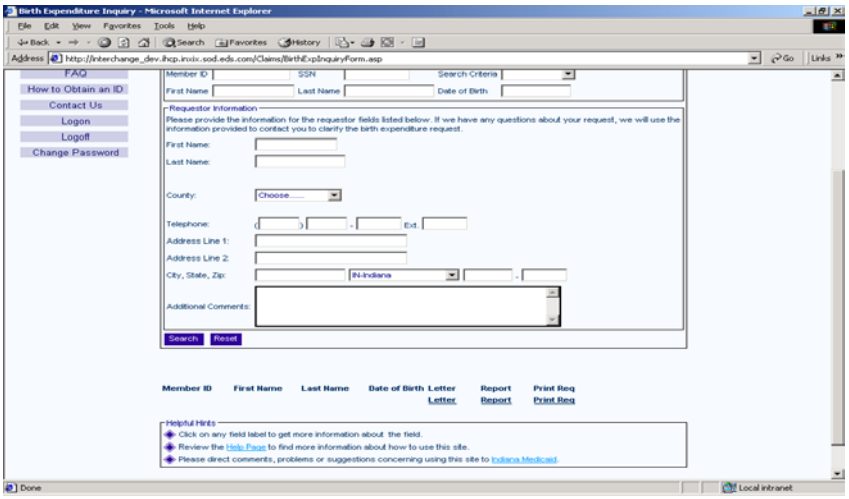

Figure 4.7 – Birth Expenditure Inquiry Window

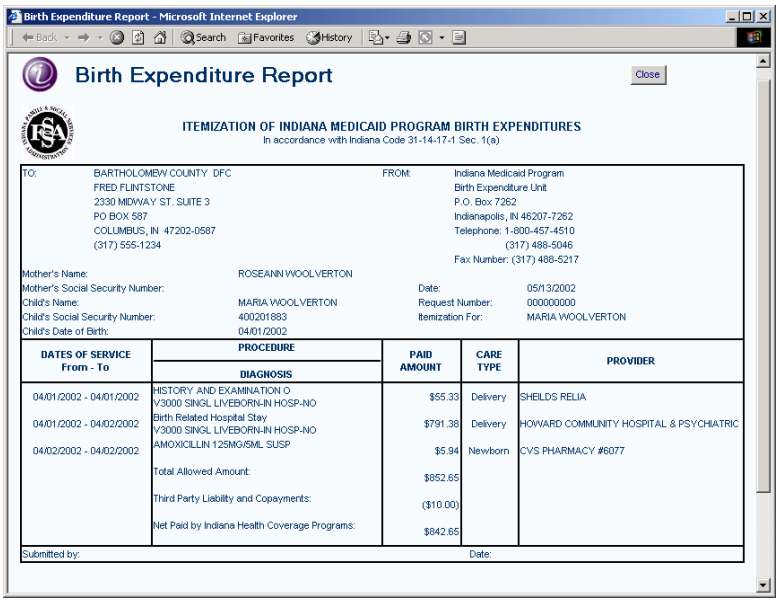

Figure 4.6 – Birth Expenditure Report Window

10. Click **Letter** on the *Expenditure Inquiry* window to display the *Birth Expenditure Paid Claims* letter. Click **Close** to return to the *Birth Expenditure Inquiry* window.

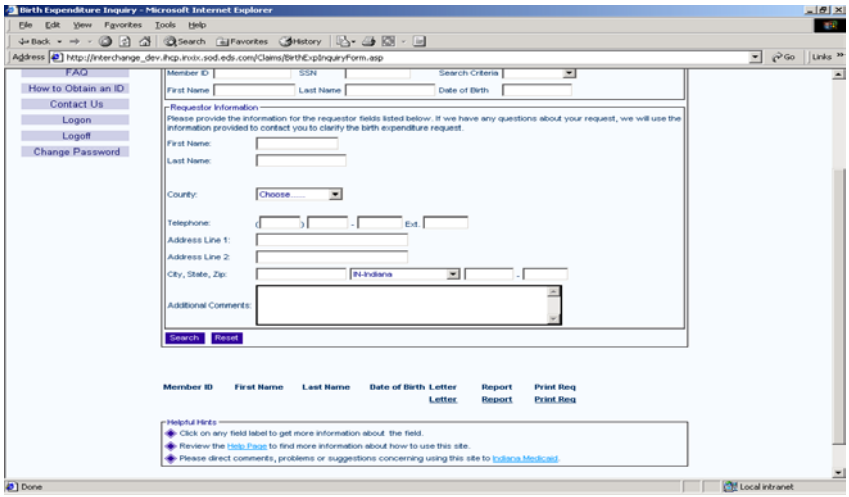

Figure 4.7 – Birth Expenditure Print Request Window

11. Click **Report** link on the *Birth Expenditure Inquiry* window to display the *Birth Expenditure Detail Report* window. Click **Close** to return to the *Birth Expenditure Inquiry* window.

12. Select the *Print Req* link to display the *Birth Expenditure Print Request Confirmation* window. To return to the *Birth Expenditure Inquiry* window click **Close**.

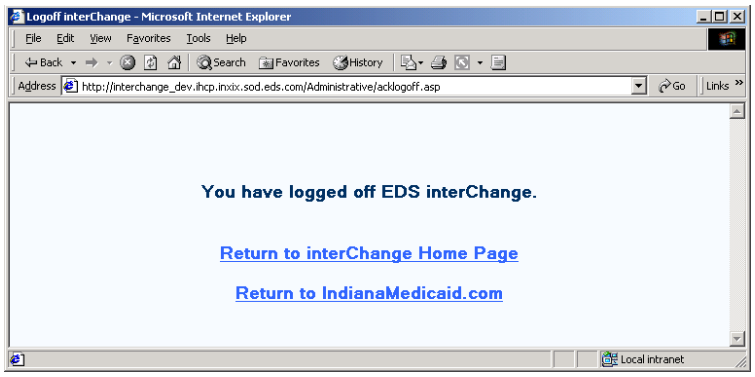

Figure 4.8 – EDS interChange Logoff Window

13. Click **Logoff** located in the navigation bar on the left side of the *Birth Expenditure* window to exit EDS interChange when birth expenditure requests are complete.

14. Type the request number, dollar amount, and the date completed into the Excel spreadsheet. Refer to the *Birth Expenditure Request* portion of this section.

15. Pick up letters from the Operations Department on the 10th floor the following day.

16. Compare the letters against the *TPL-0105-D Birth Expenditure Request by County* report that is included with the batch of letters.

17. After validation, place in an interoffice envelope, address to Nicole Love at the OMPP, and place in the outgoing mail.

18. The *Birth Expenditure Summary* report requires a signature and embossing with the State seal by the OMPP. The OMPP returns the letters via interoffice mail within two business days.

19. Upon receipt of the signed and embossed Birth Expenditure reports and the letters update the Excel spreadsheet with the date the documents returned from the OMPP, the date mailed, and place letters in outgoing mail.

Section 5: PCG Discovery

Overview

An outside vendor, Public Consulting Group (PCG), Inc. is responsible for locating other insurance information on IV-D and Medicaid children. PCG obtains a file from IV-D listing the children and an eligibility tape from EDS to run against other insurance entities. Once other insurance information is located, PCG verifies the information and forwards the tape to EDS to load into Indiana*AIM* and update the member's information on the *TPL Resource File*.

Processing the PCG Tape

The following steps ensure timely receipt, update, and response to information:

1. PCG creates the tape and submits the tape to EDS. The tape is sent to the attention of EDS, Computer Operations. The tape must include a label indicating PCG, the date in MM/DD/YYYY format, a contact name, and telephone number. The schedule in figure 5.1 provides the submission dates from PCG to EDS. EDS shares this schedule with OMPP and PCG. PCG is required to notify the Computer Operations Department when the tape cannot be submitted as scheduled.

Table 5.1 – PCG Submit Schedule

PCG Submit Dates	
April 15, 2004	September 15, 2004
May 17, 2004	October 15, 2004
June 15, 2004	November 15, 2004
July 15, 2004	December 15, 2004
August 15, 2004	

2. Computer Operations processes the tape within one business day of receipt and Indiana*AIM* updates the *TPL Resource* windows for the IHCP members. If the tape is not received within three business days of the above schedule, the Computer Operations team member notifies the casualty analyst and the health analyst, in the TPL Department that the tape was not submitted. The Computer Operations team member contacts PCG to inquire about the tape. The casualty analyst notifies the IHCP that the tape was not submitted as scheduled and that the Computer Operations Department has requested the tape from PCG.

3. After processing, the Computer Operations Department returns the tape to PCG and notifies the casualty analyst and health analyst that the tape has been returned to PCG. The return tape must include a label that states EDS, the date in MM/DD/YYYY format, a contact name, and telephone number. Figure 5.2 provides the return schedule.

Table 5.2 – TPL Return Schedule

TPL Return Dates	
March 22, 2004	August 23, 2004

TPL Return Dates	
April 22, 2004	September 22, 2004
May 24, 2004	October 22, 2004
June 22, 2004	November 22, 2004
July 22, 2004	December 22, 2004

4. The casualty and health analyst update the Excel spreadsheet at directory path *L\Package Three|PCG TPL Discovery\PCG Reports|PCG Tape Error Counts Jan_Dec 2004*. The report is submitted to the IHCP each month following the schedule in Figure 5.3.

Table 5.3 – IHCP Report Schedule

IHCP Report Dates	
March 17, 2004	August 25, 2004
April 26, 2004	September 24, 2004
May 26, 2004	October 26, 2004
June 24, 2004	November 24, 2004
July 26, 2004	December 28, 2004

5. The TPL health analyst conducts a random audit of five percent of the total records accepted in the *TPL Resource* files in Indiana*AIM*. The audit is conducted from the report *TPL-7311* found in OnDemand. The results are submitted to the IHCP, using the audit form from directory path *L:/Package Three/PCG TPL Discovery/Audits*. Figure 5.4 provides the scheduled dates for reporting the audit results.

Table 5.4 – TPL Audit Report Schedule

TPL Audit Report Dates	
March 17, 2004	August 25, 2004
April 26, 2004	September 24, 2004
May 26, 2004	October 26, 2004
June 24, 2004	November 24, 2004
July 26, 2004	December 28, 2004

Preparing the PCG Audit Report

1. On the first Wednesday following the 18th day of the month request the *TPL 731-M* report from the On Demand application.
2. Randomly highlight 5 percent of paid records throughout the report.
3. Start with the first paid record highlighted on the report and type that RID into the *TPL Search Resource* window in Indiana*AIM* to verify the policy information provided by PCG. Be sure to verify the carrier numbers on the policy. There is a possibility of duplicate policies because PCG uses one carrier number and EDS uses another for a single policy. Call both carriers to verify multiple polices.

4. Call the insurance carrier provided by PCG to verify the policy is correct. Ask for the effective and termination dates. Ask about coverage codes, especially for pharmacy, and verify the carrier mailing address and phone number.
5. If the record is correct, go to the next paid record identified for audit and complete Steps 1 through 5. If the record is incorrect, continue to Step 6.
6. Is the policy termination date prior to the date PCG tried to enter into Indiana*AIM*? The run date of the *TPL-7311-M* report is the date that PCG tried to enter a policy.
7. If the carrier cannot locate the member, terminate the policy in Indiana*AIM* and document the company called, person's name, and the date.
8. When the 5 percent audit is complete, open the report for the previous month at directory path *L: Package Three/PCG TPL Discovery/Audits*. Complete the report with the current month's audit findings.
9. Email the audit report to the appropriate person at the IHCP and follow-up the e-mail by sending the hard copy of the audit report and the *TPL 7311-M* report.
10. Keep a copy of the *TPL 7311-M* report showing the audited records in the appropriate file folder.

Retrieving the Carrier Match Validation Report

1. To retrieve the Carrier Match Validation Report (*TPL 7311-M*) log on to OnDemand32 English.
2. Highlight and click **TPL Reports.**

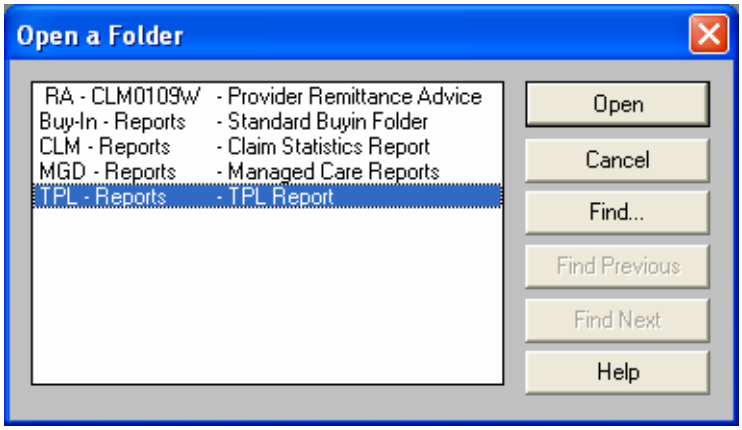

Figure 5.1 – OnDemand Open Folder Window

3. Scroll through *TPL Reports* to *TPL 7311-M*.
4. Type the dates in the *Report Date Between* field in MMDDYYYY format.

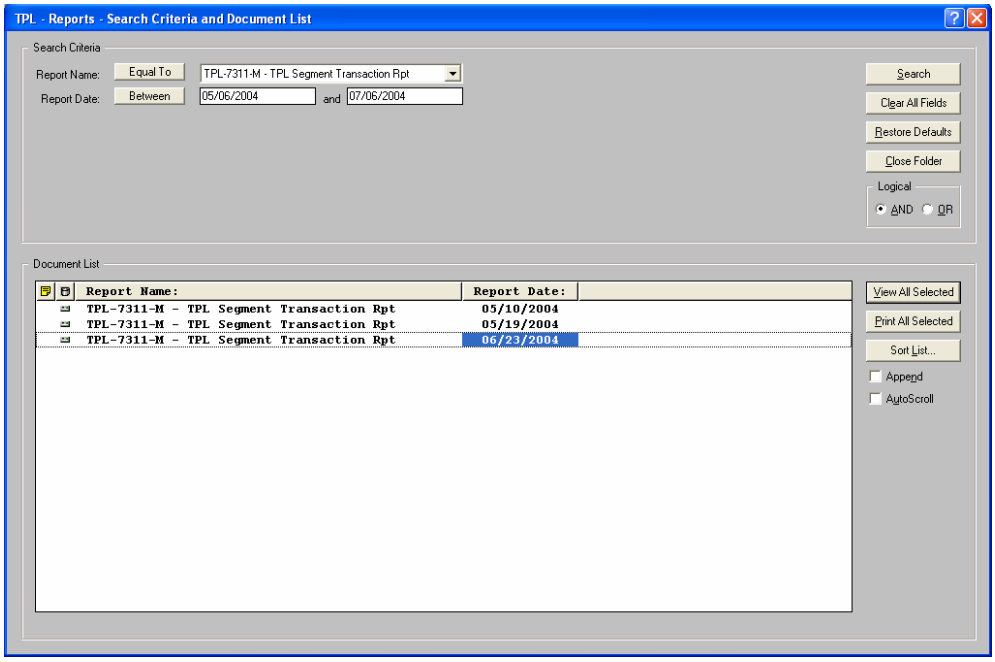

Figure 5.2 – Search Criteria and Document Window

5. Highlight the report for the current month date.
6. Double-click the highlighted date to display the report.

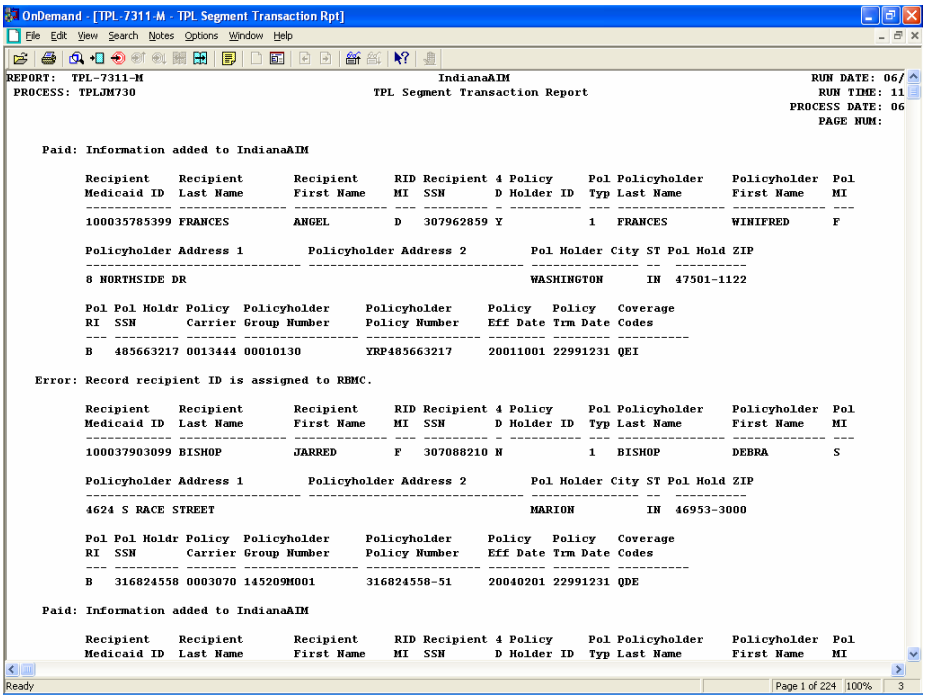

Figure 5.3 – TPL Segment Transaction Report Window

7. Save this report to an Excel spreadsheet using directory path *L:\Package Three\PCG TPL Discovery Process\PCG Reports\ PCG Submission 2004\PCG Tape Submission.xls* indicating the date in MDDYY format.
8. Send a tape of the current month's report to the appropriate PCG contact. Keep a paper copy for the audit file.

Index